HEALTH SCIENCES LIBRARY
UNIVERSITY OF MARYLAND
BALTIMORE

Digitized by the Internet Archive
in 2016

https://archive.org/details/imjillinoismedic1421illi

Illinois Medical Journal

OFFICIAL JOURNAL OF THE
ILLINOIS STATE MEDICAL SOCIETY

HEALTH SCIENCES LIBRARY
UNIVERSITY OF MARYLAND
BALTIMORE

AUG 2 '72 STACKS AUG 16'72

REC'D CIRCULATES

SEP 20 '72

RET'D SEP 20 '72

VOLUME 142 / NO. 1 / JULY 1972

Prompt relief of pain is a lot of what the practice of medicine is all about... East or West.

In much of the Far East, the analgesic efficacy of Empirin® Compound with Codeine would probably be measured against acupuncture, an ancient and traditional therapeutic system.

In America, codeine sets such a high standard for oral analgesia, that it has become a criterion in terms of which other major oral analgesics are most often measured.

Synthetic and other oral analgesics may offer some of the properties of codeine, but not one can provide both its benefits and potency. And codeine provides an antitussive bonus.

HEALTH SCIENCES LIBRARY
UNIVERSITY OF MARYLAND
BALTIMORE



Empirin Compound with Codeine is the most widely used, and probably the most pharmaceutically elegant analgesic preparation providing codeine. It's the time-tested combination for predictable pain relief . . . whether the pain is visceral or musculoskeletal; acute or chronic.

New prescription flexibility. At your discretion, and where state law permits, a prescription for Empirin Compound with Codeine may now be refilled up to five times in six months.

Empirin Compound with Codeine No. 3 contains codeine phosphate (32.4 mg.) gr. ½. No. 4 contains codeine phosphate* (64.8 mg.) gr. 1. *(Warning—may be habit-forming.) Each tablet also contains: aspirin gr. 3½, phenacetin gr. 2½, caffeine gr. ½. Bottles of 100 and 1000.*



But for relief of Western pain

EMPIRIN® COMPOUND C CODEINE

Burroughs Wellcome Co., Research Triangle Park, North Carolina 27709

X 14.3

BLUE SHIELD REPORT FOR Illinois Physicians

Blue Shield and Medicine Need Each Other

Medicine and Blue Shield have come a long way together. This was the reflection of Ned F. Parish, President of the National Association of Blue Shield Plans, as he addressed this year's business meeting of the 71 Member Plans. Parish emphasized the importance of Professional Relations in his remarks.

"Blue Shield was organized by physicians in the beginning, but it is clear in every document and from the memories of those who were around at the time, that these physicians helped establish Blue Shield to serve the public.

I think there is no greater monument to the spirit and dedication of doctors than Blue Shield. Every physician can be proud that he is a member of a profession that shares a major responsibility for helping to build a strong system that provides the public with relatively easy access to medical care.

But, he must also know that it does not belong to him. Nor to me. Nor to you. It belongs, instead, to those 66 million Americans who have joined together to form a health protection phenomenon known as Blue Shield.

I believe a large part of Blue Shield's professional relations problems have resulted from the impact of Medicare and Medicaid—and to a greater extent —the uncertainty of new Federal legislation.

To a certain extent, we are victims of circumstances that are not all of our own making. And this is one very important reason that we must have strong, creative public and professional relations efforts. It is incumbent upon us to make sure we are in control of those circumstances that may affect Blue Shield. We are in a position to help improve communications between the profession and the public by making sure that both fully understand Blue Shield's role in health care. But, in order to accomplish this, we need the cooperation of the medical profession.

So let's try to solidify our front through a little better understanding of the mutual contributions each has made.

Simply stated, Medicine's contributions to Blue Shield include the following:

1. It helped Blue Shield get established—and again I remind you—for the benefit of the public.

2. In certain Plan areas, Medicine accepted reduced payments to keep the Plan from financial disaster.

3. It contributed untold hours to Blue Shield Board and committee functions—without charge—to develop programs that the public needs.

4. Medicine has also provided peer review committees to help establish claims review guidelines and to adjudicate the tough cases.

5. Physicians signed participating agreements with Blue Shield—individually or through medical societies. This gave Blue Shield an opportunity to help itself and the medical profession to be of greater service to the public.

What have the Blue Shield Plans done for Medicine? I can draw an equally impressive list.

1. Blue Shield has given the leadership to, and participated largely in, the development of the world's largest and most viable private system for the delivery and financing of medical care.

2. It has assured direct payment to physicians without losses from bad debts and without additional collection expense. Today, on private business alone, Blue Shield pays doctors more than 2½ billion dollars a year.

3. Blue Shield—through the physician voice on Boards and committees—has been receptive to Medicine's views.

4. It has undertaken experimental activities to extend prepayment coverage into new areas of medical services.

5. It has played a "buffer role" in Medicare. Regardless of what many doctors may think of Medicare, the program would have been even less acceptable if it were not for Blue Shield.

6. Blue Shield is working to develop more effective cost containment programs and documenting the effectiveness of these efforts.

From these two lists it is obvious that Blue Shield and Medicine need each other. In the face of the challenges confronting both of us, I would urge a re-examination and understanding of Blue Shield as an organization to serve the public's health care needs through a coordinated effort between Medicine and Blue Shield."

(This report is a service to the physicians of Illinois)

ASK BLUE SHIELD

• • • ABOUT MEDICARE

Billing For Patients Covered By Medicare And Public Aid

How do I file for benefits when my patient is a Public Aid recipient who is over 65? That's a perplexing question for a new physician or even for one who has been in practice for many years and has had trouble collecting benefits for these patients.

For a Public Aid recipient who is over 65, Medicare coverage takes precedence over the Public Aid coverage. This means that Medicare must adjudicate the claim before Public Aid can act.

To file for benefits for this patient, you simply complete an SSA 1490, Request for Medicare Payment form, in triplicate. The SSA 1490 is completed in the same manner as for any other patient who is covered by Medicare with three exceptions.

1. You *must* accept assignment if you expect to receive payment from both Medicare and Public Aid.

2. The patient's Public Aid number *must* be shown in line 5 of the SSA 1490.

3. If the patient does not sign the SSA 1490, the words "Public Aid" *must* be shown in the patient's signature box.

Send the first copy of the SSA 1490 to your Medicare carrier, and the second copy to the Public Aid Office, Medical Administration, 425 South Fourth Street, Springfield, Illinois 62703. The third copy should be kept in your files.

Medicare will allow 80 per cent of the reasonable charge after the annual $50.00 Part B deductible has been met. A copy of the Explanation of Medicare Benefits (EOMB) indicating payment or nonpayment will be sent to the Public Aid office. Public Aid will match this EOMB with their copy of the SSA 1490 and adjudicate the claim to make payment under the provisions of the Public Aid law.

To prevent delays in the processing of your claims for Medicare-Public Aid patients, you should make sure that the SSA 1490 is correctly completed, signed, and that all pertinent information about the patient's condition and service performed has been included.

Gastrophotography Covered

Gastrophotography is an accepted procedure for diagnosis and treatment of gastrointestinal disorders. The photographic record provided by this procedure is often necessary for consultation and/or followup purposes and when required for such purposes, is more valuable than a conventional gastroscopic examination. Such a record facilitates the documentation and evaluation (healing or worsening) of lesions such as the gastric ulcer, facilitates consultation between physicians concerning difficult-to-interpret lesions, provides preoperative characterization for the surgeon, and permits better diagnosis of postoperative gastric bleeding to help determine whether there is a need for reoperation.

Partially Paid Bills

If a physician accepts assignment of the unpaid portion of a partially paid bill he is bound to accept the reasonable charge determination as his full charge, even though the reasonable charge is found to be equal to or less than the amount already paid by the enrollee and no Medicare benefit is payable to the physician. If the reasonable charge is less than the amount already paid, the physician must refund the difference. However, if a physician submits an apparently assigned claim which shows that the enrollee *has already paid* the physician's actual charge in full, there is no assignment and he is not bound by the reasonable charge limitation.

Effect Of The Deductible

A physician who accepts assignment on a bill is bound by the reasonable charge as determined by the carrier with respect to covered services shown on the bill, even though no benefit is payable to him because of the deductible. Thus, if a physician submits an assigned bill for $40, on which the reasonable charge is $35, and the enrollee has not yet met any part of the deductible, the physician is bound by the assignment agreement, even though no Medicare payment can be made to him. The physician, therefore, is entitled to collect only the $35 reasonable charge from the patient.

(This report is a service to the physicians of Illinois)

IMJ

illinois medical journal

volume 142, number 1 July, 1972

staff

editor Theodore R. Van Dellen, M.D.
managing editor Richard A. Ott
assistant editor Gerald A. Frankel
advertising manager John A. Kinney
executive administrator Roger N. White

Abstracts of Board Actions 26

clinical articles

Sarcoma botryoides of the cervix
James A. O'Leary, M.D., Douglas Lambrecht, B.S. 33

Maternal death study case report No. 5
Robert E. Hartman 42

Drugs in the treatment of depression
Gerald L. Klerman, M.D. 44

Ano-Rectal Crisis
Crile Doscher, M.D. 54

Kinked internal carotid artery
Joseph C. Cleveland, M.D., William M. McCormack, M.D. 56

trauma center

Infections following abdominal trauma
Ronald Lee Nichols, M.D., Haragopal Thadepalli, M.D. Sherwood L. Gorback, M.D. 50

surgical grand rounds

Toxic goiter and pregnancy 37

features

the presidents page 8
the viewbox 43
membership forum 48
ekg of the month 49
clinics for crippled children 58
new pharmaceutical specialties 59
investment corner 61
practice management 62
editorial 63
obituaries 64
doctors library 65
what goes on 67
pulse of the doctor's wife 69
doctors news 77

(cover by Mike Ahearn illustrates the progress made by American physicians from our revolution (to July 4, 1972. Cover story page 71.)

Microfilm copies of current as well as some back issues of the *Illinois Medical Journal* may be purchased from Xerox University Microfilms, 300 North Zeeb Road, Ann Arbor, Mich. 48106.

Published monthly by the Illinois State Medical Society, 360 N. Michigan Ave., Chicago, Ill., 60601.
Copyright, 1972, The Illinois State Medical Society.
Subscription $5.00 per year, in advance, postage prepaid, for the United States, Cuba, Puerto Rico, Philippine Islands and Mexico. $7.50 per year for all foreign countries included in the Universal Postal Union. Canada $5.50 U.S. Single current copies available at 75c.

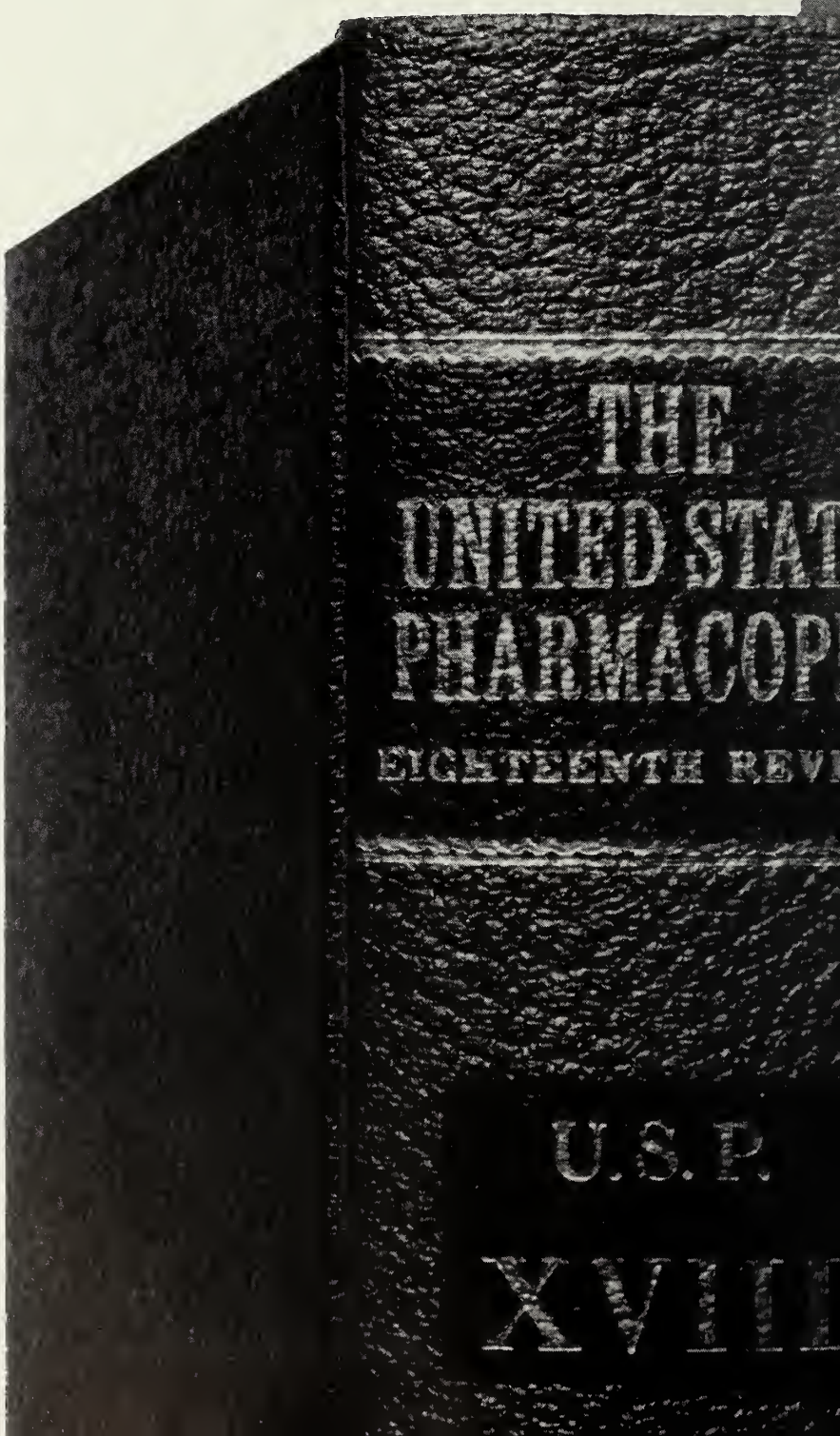
Second class postage paid at Chicago, Ill. and at additional mailing offices. When moving please notify Journal office of new address including old mailing label with notification, if possible. POSTMASTER: Send notice on form No. 3579 to Illinois State Medical Society, 360 N. Michigan Ave., Chicago, Ill. 60601.

Pharmaceutical advertising must be approved by the ISMS Publications Committee. Other advertising accepted after review by Publications Committee or Board of Trustees. All copy or plates must reach the Journal office by the fifteenth of the month preceding publication. Rates furnished upon request.

'Original articles will be considered for publication with the understanding that they are contributed only to the Illinois Medical Journal. The ISMS denies responsibility for opinions and statements expressed by authors or in excerpts, other than editorial or allied views or statements which reflect the authoritative action of the ISMS or of reports on official actions, policies or positions. Views expressed by authors do not necessarily represent those of the Society; any connection with official policies is coincidental.

REGISTERED AIA MEDIA DATA FORM

THE U.S.P. DESCRIBES ONLY ONE STANDARD FOR CONJUGATED ESTROGENS...



..THE PREMARIN® STANDARD
(CONJUGATED ESTROGENS TABLETS, U.S.P.)

In the latest edition of the United States Pharmacopeia—*an "official compendium" of drug potency, quality, and purity*—there is now a clear distinction made between conjugated estrogens and other estrogens. And of the leading estrogen preparations available today, PREMARIN is the only one whose composition meets all of the U.S.P. specifications for conjugated estrogens.

We're of course gratified that the United States Pharmacopeia has included conjugated estrogens in the U.S.P. XVIII, and that PREMARIN meets the U.S.P. standard for conjugated estrogens. But, above and beyond meeting all of the U.S.P. specifications, PREMARIN continues to be manufactured with natural estrogens exclusively and contains no synthetic supplement.

For more than 28 years it has been manufactured under the strictest quality control to assure consistency in product potency, activity and stability. For more than 28 years it has been the research standard in its field. For more than 28 years it has been the most widely prescribed agent of its kind.

PREMARIN. Assurance of quality for you and your patients.

BRIEF SUMMARY
(For full prescribing information, see package circular.)
PREMARIN® (Conjugated Estrogens Tablets, U.S.P.)
Indications: PREMARIN provides specific replacement therapy in the management of estrogen deficiency states, notably in the menopause and postmenopause.
Precautions: *In the female:* To avoid continuous stimulation of breast and uterus, cyclic therapy is recommended (3 week regimen with 1 week rest period—Withdrawal bleeding may occur during this 1 week rest period).

Failure to control breakthrough bleeding or unexpected recurrence is an indication for curettage.

In the male: Continuous therapy over prolonged periods of time may produce gynecomastia, loss of libido, and testicular atrophy.
Dosage and Administration: Cyclic administration is recommended (3 weeks of daily estrogen therapy and 1 week off).

If patient has not menstruated within last two months or more, cyclic administration is started arbitrarily. If patient is menstruating, cyclic administration is started on day 5 of bleeding.

If breakthrough bleeding occurs (bleeding or spotting during estrogen therapy), increase estrogen dosage as needed to stop bleeding. In the following cycle, the dosage level which was employed for hemostasis should be used for daily administration. In subsequent cycles, the estrogen dosage is gradually reduced to the lowest level which will maintain the patient symptom-free. (See Precautions.)

Menopause (natural or artificial)—PREMARIN 1.25 mg. daily, cyclically. Adjust dosage upward or downward according to severity of symptoms and response of the patient. For maintenance, adjust dosage to lowest level that will provide effective control. Many clinicians favor continuing cyclic estrogen replacement therapy throughout the postmenopause as a protective influence against accelerated degenerative changes at the cellular level.

Postmenopause—(If uterus is intact the patient is considered postmenopausal from one year after cessation of menstruation to end of life span.) If the presenting symptoms are those of the menopause, see above for dosage. As a protective measure against premature degenerative changes in bone and cellular metabolism (*e.g.* atrophic vaginitis, osteoporosis), give PREMARIN daily and cyclically. Adjust dosage to lowest effective but subbleeding level.

Estrogen Deficient Atrophic Vaginitis, Kraurosis Vulvae, and Pruritus Vulvae—1.25 mg. to 3.75 mg. daily, or more, cyclically—depending on the tissue response of the individual patient.
How Supplied: PREMARIN (Conjugated Estrogens Tablets, U.S.P.). No. 865—Each *purple* tablet contains 2.5 mg. No. 866—Each *yellow* tablet contains 1.25 mg. No. 867—Each *red* tablet contains 0.625 mg. No. 868—Each *green* tablet contains 0.3 mg.

Bottles of 100 and 1,000. The 1.25 mg. potency also available in unit dose package of 100.

AYERST LABORATORIES
New York, N.Y. 10017
Ayerst.

7149

PREMARIN® (Conjugated Estrogens Tablets, U.S.P.) continues as the standard for conjugated estrogen therapy

the presidents page



ISMS RESPONSIVE TO COUNTY SOCIETY NEEDS

The Illinois State Medical Society IS responsive to the needs of county medical societies. Let's look at one resolution introduced by the Kane County Medical Society at our annual meeting in March.

Adopted by the House of Delegates, the resolution called for ISMS opposition to the extension and use of triplicate prescription forms for dangerous drugs to include amphetamines, phenmetrazine and methylphenidate.

I testified at a hearing of the Illinois Department of Law Enforcement in Chicago on April 12—just four weeks after the resolution was approved by the House—to outline ISMS opposition to inclusion of amphetamines and similar drugs under Schedule II of the Illinois Controlled Substance Act.

I emphasized the following points:

• While ISMS agrees that control of drugs with abusive potential is necessary, such control should *not* interfere with medical diagnosis and treatment.

• Extending the use of triplicate forms to amphetamines and similar drugs can only add to the already heavy burden of paperwork Illinois physicians must bear—rescheduling at the state level is unnecessary since federal controls already apply to such drugs.

• Requiring triplicate forms for amphetamines can only increase costs for the physician . . . the pharmacist . . . and eventually . . . the patient! This is in addition to increased enforcement costs.

• Triplicate forms can be forged or counterfeited as easily as any ordinary prescription pad.

• Additional regulations which tend to interfere with the proper prescribing of drugs are an abridgement of the physician's right to treat patients and an abridgement of the patient's right to receive the best possible care as well.

The point I tried to make to the commission is that effective control of drug abuse should begin with public education and elimination of

(Continued on page 66)

During anginal attacks, patients may suffer intense apprehension. More frequently, however, they experience a continuing sense of less severe but nonetheless disproportionate anxiety.

Reduction of such clinically significant anxiety is important, since undue emotional stress may precipitate further anginal episodes.

Adjunctive Librium (chlordiazepoxide HCl) may be especially suitable for relief of clinically significant anxiety and emotional tension in anginal patients because of its generally prompt therapeutic effectiveness and wide margin of safety. In a recent double-blind randomized study,* Librium (chlordiazepoxide HCl) was administered for relief of moderate anxiety in 20 anginal patients seen in office practice over a 20-week period. Symptoms of emotional distress related to anxiety were rated at base-line, one week, two weeks and monthly thereafter. Relief was obtained notably early in therapy. The clinical results demonstrated that Librium offers the coronary patient an antianxiety drug that, in the author's opinion, is both effective and safe. In general use, the most common side effects reported have been drowsiness, ataxia and confusion, particularly in the elderly and debilitated. (See summary of prescribing information.)

Librium (chlordiazepoxide HCl) is used concomitantly with certain specific medications of other classes of drugs, such as cardiac glycosides, diuretics and antihypertensive agents, whenever anxiety is clinically significant. The drug should be discontinued after anxiety has been reduced to appropriate levels.

The positive power of adjunctive Librium® (chlordiazepoxide HCl)

10-mg, 25-mg capsules up to 100 mg daily

for moderate to severe anxiety accompanying angina pectoris

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Indicated when anxiety, tension and apprehension are significant components of the clinical profile.

Contraindications: Patients with known hypersensitivity to the drug.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. As with all CNS-acting drugs, caution patients against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported. Use of any drug in pregnancy, lactation, or in women of childbearing age requires that its potential benefits be weighed against its possible hazards.

Precautions: In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (*e.g.*, excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

Adverse Reactions: Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.

Supplied: Librium® Capsules containing 5 mg, 10 mg or 25 mg chlordiazepoxide HCl. Libritabs® Tablets containing 5 mg, 10 mg or 25 mg chlordiazepoxide.

*Levine, S.: "Angina Pectoris and Emotional Overlay," Scientific Exhibit presented at the Annual Meeting of the Maine Medical Association, Kennebunkport, Me., June 13-15, 1971.

A copy of the Levine study may be obtained from your Roche representative.

ROCHE

Roche Laboratories
Division of Hoffmann-La Roche Inc.
Nutley, N.J. 07110

Abstracts of Board Actions Board of Trustees Meeting

These abstracts are published so that members of the Illinois State Medical Society may keep advised of the actions of the Board of Trustees. It covers only major actions and is not intended as a detailed report. Full minutes of the meetings are available upon any member's request to the headquarters office of the ISMS.

May 6-7, 1972 **Chicago, Illinois**

Increase in Liability Insurance Rates

Responding to news that premium rates will be increased substantially June 1 for participants in the ISMS-sponsored professional liability insurance program, the Board of Trustees directed that the following actions be taken:

1. File an objection with the Illinois Director of Insurance indicating that physician's fees cannot be raised sufficiently under the U.S. Price Commission regulations to accommodate proposed rate increases.
2. Send a telegram to the Chairman of the U.S. Price Commission asking that physicians be allowed to raise fees beyond the prescribed 2.5% to cover increased insurance rates, if they are approved.
3. Request Parker-Aleshire, administrator of the ISMS-sponsored malpractice insurance program, to assist participants in seeking redress from Phase II restrictions to cover the increased cost of insurance.
4. Request Parker-Aleshire to help ISMS obtain legislative relief from the growing malpractice claim problem.
5. Appeal to Governor Ogilvie and President Nixon for help in protecting physicians from the malpractice dilemma or face a drastic change in health care delivery.
6. Authorize one or more insurance brokers, in addition to Parker-Aleshire, to study the malpractice problem in Illinois with a view to designing a new professional liability program for ISMS members.
7. Instruct the AMA Delegation to introduce a resolution requesting the AMA to seek solutions at the national level.
8. Notify ISMS members immediately that the above steps are being taken.

Malpractice Insurance for Psychiatrists

In a related action the Board has referred to the Insurance Committee a complaint from the Council on Mental Health and Addiction that psychiatrists using certain sedation drugs were being classified as anesthesiologists, even though the Society has no control over programs not sponsored by ISMS.

Illinois Association of Professions

Acting on a recommendation of the Executive Committee, the Board of Trustees voted to drop ISMS membership in the Illinois Association of the Professions, effective immediately. The Executive Committee said IAP had lost sight of its original objective and has embarked on legislative activities that do not always coincide with that of ISMS.

Hospital Key Man Program

The Board of Trustees has approved a plan to improve communications with members by establishing a Hospital Key Man Program in Cook County. Heart of the plan is the appointment of one physician at each hospital charged with the responsibility of keeping all physicians on the staff aware of what the medical society is doing with respect to socio-economics, legislation, scientific activities, etc. It is expected that communications can be made within 48 hours.

Council and Committee Appointments

The Board approved the appointment of members of eight councils, nine committees of the Board and nine free-standing or direct-reporting committees. In an effort to streamline the Society's council structure, the House of Delegates last March abolished all committees existing under councils. However, it gave the Board of Trustees authority to create—on an ad hoc basis—whatever committees it deems necessary for 1972-73.

While most ad hoc committees will continue to function under the umbrella of councils, there are some whose responsibilities are of such specialized nature that it would be impractical to have them report to a council. The following, therefore, were designated as free standing committees:

Liaison with Blue Cross and Blue Shield, Hospital Manpower, Insurance, Drugs and Therapeutics, Student Loan Fund, Health Care Priority for Legislative Purposes, Certificate of Need (HB-2653), Joint Practice with Nurses, and a special project committee for the Illinois Department of Mental Health.

Annual Meeting Dates Set

By official action, the Board approved plans for conducting the 1973 Annual Meeting March 25-28 at the Conrad Hilton Hotel in conjunction with the Chicago Medical Society's Clinical Conference. Dr. Sunderland asked that major scientific programs not be scheduled at the same time the House is in session.

School Employee Physical Examination Forms

The Board approved a school employee physical examination form developed by the ISMS Council on Environmental & Community Health in cooperation with the Office of the Superintendent of Public Instruction, the Illinois Department of Public Health, and the Chicago Board of Education. The 1971 House of Delegates ordered that such a form be developed for recommended use in Illinois.

Group Life Insurance Program Approved

A new ISMS-sponsored group life insurance program will be offered to members this summer. On recommendation of its Insurance Committee, the Board approved a program offered by the Northwestern Life Insurance Company.

Appointments and Authorizations

Dr. Wayne Leimbach, Aurora, and Dr. Joseph Robbins, Chicago, were recommended for appointment to the Clinical Laboratory and Blood Bank Advisory Board of the Illinois Department of Public Health.

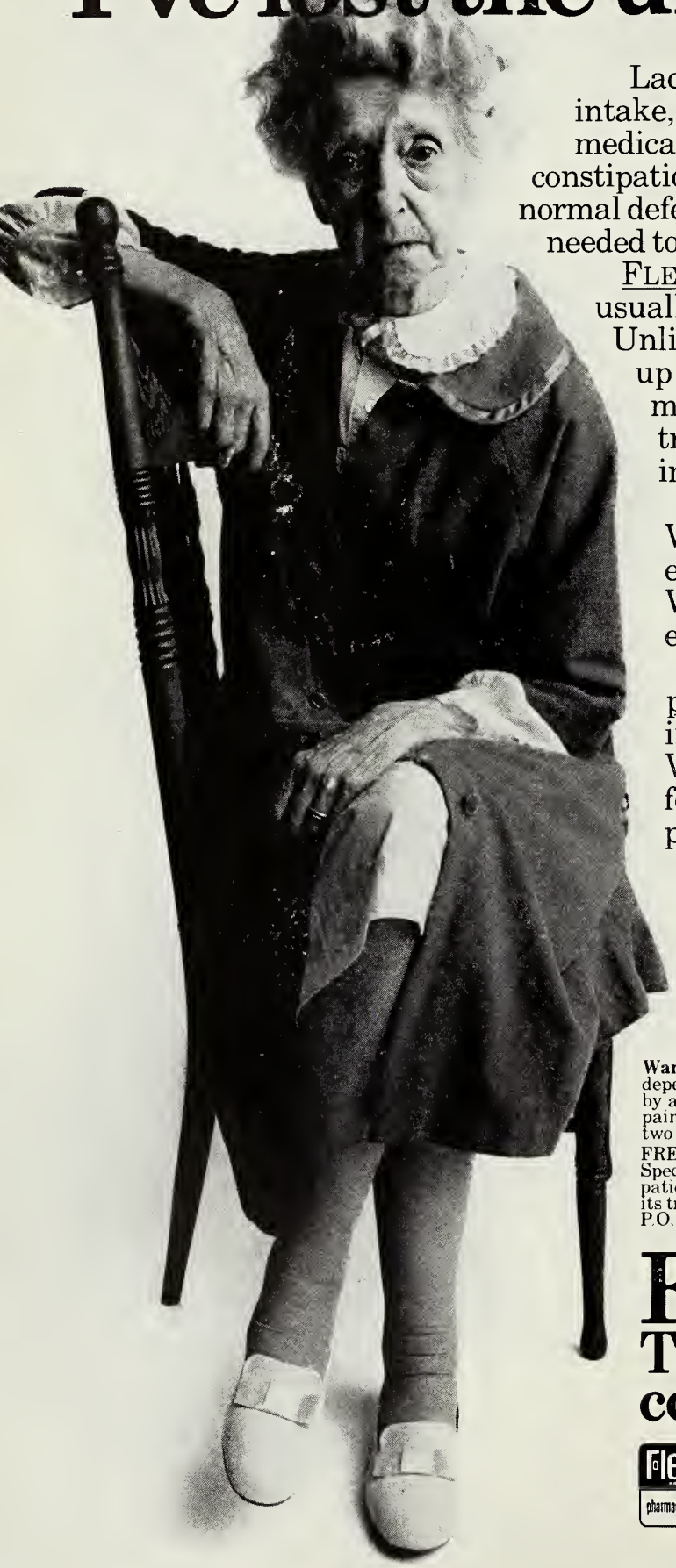
Drs. Grant Johnson, Springfield; Jacob E. Reisch, Springfield; Paul A. Van Pernis, Rockford; J. Robert Thompson, Chicago and Fred Nathan, Chicago, were recommended for appointment to the Advisory Board on Necropsy Service to Coroners.

The Board reappointed the following as ISMS representatives to other organizations:

1. Dr. Arkell M. Vaughn—Swanberg Foundation, Quincy.

(Continued on page 81)

To tell you the truth, I've lost the urge.



Lack of exercise, insufficient fluid intake, diet deficient in bulk, and certain medications can all contribute to constipation in the aging. Gradually the normal defecation "urge" is lost. And help is needed to restore the normal bowel function.

FLEET ENEMA works quickly – usually within 2 to 5 minutes. Unlike oral laxatives, which can take up to 24 hours. And oral laxatives may actually irritate the intestinal tract or retard digestion and further inhibit regularity.

FLEET ENEMA is gentle, too. Works without the burning often experienced with suppositories. Without the discomfort of soapsuds enemas.

FLEET ENEMA induces a physiological pattern of evacuation in the left colon and the rectum. Where it's needed. Helpful especially for the geriatric patient with poor intestinal tone.

And FLEET ENEMA is easy. Ready to use. Completely disposable. A timesaving plus in nursing home care – or at home.

FLEET ENEMA. For geriatric patients. Helps restore the urge.

Warning: Frequent or prolonged use of enemas may result in dependence. Take only when needed or when prescribed by a physician. Do not use when nausea, vomiting, or abdominal pain is present. **Caution:** Do not administer to children under two years of age unless directed by a physician.

FREE BOOKLET. *The Professional Treatment of Constipation.* Specifically prepared to assist you in providing your older patients with more detailed information about constipation and its treatment. For copies simply write to C.B.FLEET CO.,INC., P.O. Box 1100, Lynchburg, Va. 24505.

Fleet® Enema

The professional aid t constipation relief

Fleet pharmaceuticals

C.B. FLEET CO., INC.
Lynchburg, Va. 24505

F70A72

IMJ
Illinois Medical Journal
Vol. 142, No. 1, July, 1972

Sarcoma Botryoides Of The Cervix

By J. Douglas Lambrecht, B.S., and James A. O'Leary, M.D.

SARCOMA BOTRYOIDES is an extremely rare malignant tumor which has caused much controversy as to its pathologic classification and histogenesis since it was first described in the middle of the last century. McFarland, in his review of the literature prior to 1935, found 119 different names for this tumor. Ober defines sarcoma botryoides as a tumor occurring predominantly in infants and children in almost any part of the urogenital region, which grows as a polypoid mass derived from mesenchymal cells that exhibit any or all of the transformations commonly shown by multipotent mesenchymal cells. The tumor is characterized by a tendency to recur locally. Even after removal it may extend into adjacent pelvic viscera and occasionally may metastasize to distant organs.[14] More recently, similar tumors have been described, occurring in boys in the urethra and prostate, and in both sexes, in the bladder and such extra-urogenital regions as the common bile duct, the orbit, the middle ear, and the head and neck.[3,7,8]

The most common morphologic picture is that of a grape-like polypoid mass. Microscopically the tumor consists of an edematous, myxomatous or cellular stroma containing plemorphic cells, described as spindle, strap, stellate, racquet or round. Some of the cells have bright eosinophilic cytoplasm and a few show cross striations.

The most successful treatment is that of radical surgery, as recurrences are common with less drastic procedures.

Case Report

A 13-year-old girl who passed a piece of grape-like tissue from the vagina was referred to Loyola University Medical Center with the tentative diagnosis of sarcoma botryoides. Examination under anesthesia disclosed a 2x2 cm polypoid mass located on the posterior lip of the cervix. The uterus was normal in size with no irregularities, and the adnexa were normal. The polyp was excised, biopsy of a nodule in the

lower portion of the vagina, and a D and C were performed. Microscopic examination of the polyp confirmed the diagnosis of sarcoma botryoides. All other tissues were benign. An extensive tumor workup was normal.

A radical hysterectomy, bilateral lymph node dissection, partial vaginectomy were performed and the ovaries preserved. The abdominal exploration was normal. There were no post-operative complications. Microscopic examination of the uterus, cervix, vagina and lymph nodes showed no tumor. Six months later there was no evidence of recurrent tumor.

Discussion

Sternberg[19] considers sarcoma botryoides to be one form of mixed mesodermal or mixed müllerian tumors, which arise from specialized endometrial stroma, which retains in adult life, a latent capacity for differentiation not possessed by other müllerian derivatives.[19] More recently, there has been an attempt by several authors to place sarcoma botryoides into a separate classification from that of mixed mesodermal tumors.[3,8,10] Hilgers, in his review, demonstrated the similarities between rhabdomyosarcomas of extraurogenital origin and sarcoma botryoides of the vagina, cervix and bladder. This author[8] feels that the term sarcoma botryoides should be replaced by embryonal rhabdomyosarcoma, botryoid type.

The original histologic descriptions spoke of the tumor as having myxomatous, edematous tissue with primitive, pleomorphic cells, and varying amounts of embryonal smooth and striated myoblasts. There were also reports that included occasional adipose, cartilage and bone.

In the female genital system, sarcomas appear more frequently in the vagina in infants and young children, in the cervix in women during active reproductive life and in the uterus in postmenopausal women.[2,5,6,11,12,13] Amolsch set the average age for vaginal tumors at 22 years with 60% occurring in children under two years of age. The average age of women with cervical sarcoma was 31 years and those with sarcoma of the corpus 55 years. Hilgers reports an average age of 27.5 months as opposed to 38.3 months in 58 cases reported in the literature. Most of his patients were under 5 years of age, two-thirds of these had tumors appearing in the first 2 years of life. Diehl[4] reviewed McFarland's 44 cases of vaginal sarcoma, 34 of which were botryoid, and found that 86% occurred during the first three years of life and the rest appeared before the sixth year. Diehl claims that the most common site is the anterior vaginal wall, with the posterior and left lateral walls being the next most common site.[4]

That it is a rare neoplasm is evident by the small number of cases reported in the literature since the tumor was first described over one hundred years ago. Sternberg, stated an incidence of 0.08% of all gynecologic admissions.[17] Marcus, in describing sarcoma botryoides of the cervix, reported an incidence of 0.13% of all cervical malignancies.

The prognosis for this disease was considered poor until recently. Improved surgical techniques, better understanding of the tumor's method of spread, and recognition of the need for prompt institution of radical treatment have improved the outlook. Early forms of treatment included local excision, irradiation, or the combination of the two. Although supposed cures were claimed, most of the patients treated in this way developed recurrence of the tumor with extension into neighboring pelvic tissues, and occasional metastases to the lungs, intestines, kidneys and bones. In 1947, Ulfelder reported Meigs' successful treatment of an infant with sarcoma botryoides using radical surgery.[20] Shackman reported a 2.5 year cure with no recurrence after an anterior exenteration.[18] Ober reported 2 cases with no recurrence after 2 years using an abdomino-perineal hysterocolpectomy.[15] In 1959, Hill[9] reported a failure with hysterectomy, vaginectomy and vulvectomy procedure. He added in retrospection that an anterior exenteration might have been more successful.[9] Crawford has reported cures ranging from 1.5 years to 7 years with no recurrences at the time



J. DOUGLAS LAMBRECHT, B.S., is a second year medical student at Stritch School of Medicine, Loyola University. He has received an OB gynecology fellowship from the American Cancer Society sponsored by the Loyola University Hospital.



JAMES A. O'LEARY, M.D., received his M.D. from Georgetown University and served his internship at the Washington D.C. General Hospital. He specialized in obstetrics and gynecology at the Presbyterian Medical Center 1962-1967.

they were reported, using combined hysterectomy and vaginectomy.[2,13,21] Schade[17] reported a 3.5 year cure after radical hysterectomy, bilateral salpingo-oophorectomy, subtotal vaginectomy and pelvic lymph node dissection. In 1967, Rutledge[16] reported six cases that were treated with pelvic exenteration: One of which resulted in death due to recurrence, one in which recurrence has been managed by chemotherapy and irradiation, and four cases with cures ranging from 2 to 5 years. This author feels that the more radical exenteration procedures are the most effective techniques because of the tendency for the tumor to recur. The ovaries are usually retained if the tumor is localized in order that the patient's secondary sex characteristics may develop normally. Daniel[3] considers one year survival without recurrence to be the critical time factor in determining success. However, some recurrences have been reported several years after surgery.

Sarcoma Botryoides is a rare, malignant neoplasm, most commonly occurring in the urogenital tract, especially in the vagina of young girls. Occasional cases in males as well as cases of extra-urogenital origin in both sexes have been reported.

Once considered to be a mixed mesodermal tumor, its similarity to rhabdomyosarcomas of extra-genital origin has caused it to be considered as an embryonal rhabdomyosarcoma, of the botryoid type.

Prognosis has improved with prompt recognition and treatment with radical surgery: Either pelvic exenteration, or radical hysterectomy with partial vaginectomy and pelvic lymph node dissection. The ovaries if uninvolved are not removed, to allow proper development of secondary sex characteristics.

A case of Sarcoma Botryoides of the cervix of a thirteen year old girl is presented. Treatment was radical hysterectomy, partial vaginectomy and pelvic lymph node dissection. No evidence of recurrence of the tumor can be found after six months. ◄

References

1. Amolsch, A. L. Mixed Mesodermal Tumors of the Uterus and Vagina with a Report of Six Cases, *Amer. J. Cancer* 37:435-444, November 1939.
2. Crawford, E.J., Sarcoma Botryoides: A Case Report, *Amer. J. Obstet. Gynec.* 78:618-620, September 1959.
3. Daniel, W.W., Koss, L.G., and Brunschwig, A., *Sarcoma Botryoides* of the Vagina, *Cancer* 12:74-84, January-February 1959.
4. Diehl, W.K., and Haught, J.S., Sarcoma of the Vagina, *Amer. J. Obstet. Gynec.* 52:302-310, August 1946.
5. Dorgan, L.T., Sarcoma Botryoides: A Case Report, *Obstet. Gynec.* 2:127-132, August 1953.
6. Duckett, H.C., Davis, C.D. and McCall, J.B., Sarcoma Botryoides—A Clinical and Pathologic Review and Report of Four New Cases, *Obstet. Gynec.* 9: 517-522, May 1957.
7. Farinacci, C.J., Fairchild, J.P., Sulak, M.H., and Gilpatrick, C.W., Sarcoma Botryoides (A Form of Embryonal Rhabdomyosarcoma) of the common bile duct, *Cancer* 9: 408-17, March-April 1956.
8. Hilgers, R.D., Malkasian, G.D., Jr., Soule, E.H., Embryonal Rhabdomyosarcoma (Botryoid Type) of the Vagina, *Amer. J. Obstet. Gynec.* 107: 484-502, June 1970.
9. Hill, H.H., Lebherz, T.B., and McMahon, E.B., Sarcoma Botryoides, A Case Report, *Amer. J. Obstet. Gynec.* 78:621-627, September 1959.
10. Horn. R.C., Jr., and Enterline, H.T., Rhabdomyosarcoma, A Clinicopathological Study and Classification of 39 cases, *Cancer* 11:181-199, January-February 1958.
11. Kulka, E.W., and Douglas, G.W., Rhabdomyosarcoma of the Corpus Uteri, A Report of a Case Associated with Adenocarcinoma of the Cervix, with a Review of the Literature, *Cancer* 5:727-736, July 1952.
12. McFarland, J., Dysontogenetic and Mixed Tumors of the Urogenital Region, *Surg. Gynec. Obstet.* 61:42-57, July 1935.
13. Marcus, S.L., Mullerian Mixed Sarcoma (Sarcoma Botryoides) of the Cervix, *Obstet. Gynec.*, 15:47-57, January 1960.
14. Ober, W.B., and Edgcomb, J.H., Sarcoma Botryoides in the Female Urogenital Tract, *Cancer* 7:75-91, January 1954.
15. Ober, W.B., Smith, J.A., and Rouillard, F.C., Congenital Sarcoma Botryoides of the Vagina, Report of Two Cases, *Cancer* 11:620-623, May-June 1958.
16. Rutledge, F., and Sullivan, M.P., Sarcoma Botryoides, Ann, N.Y., *Acad, Sci.* 142:694-708, May 1967.
17. Schade, F.F., Sarcoma Botryoides of the Cervix Uteri, A Report of a Case in an Adult with Survival, *Obstet. Gynec.* 26:731-733, November 1965.
18. Shackman, R., Sarcoma Botryoides of the Genital Tract In Female Children, *Brit. J. Surg.*, 38:26-30, July 1950.
19. Sternberg, W.H., Clark, W.H., and Smith, R.C., Malignant Mixed Mullerian Tumors (Mixed Mesodermal Tumors of the Uterus) A Study of 21 cases, *Cancer* 7:704-724, July 1954.
20. Ulfelder, H., and Quan, S.H., Sarcoma Botryoides Vaginal, Complete Excision of the Tumor in an Infant by the Combined Abdominal and Perineal Approach. *Surg. Clinics N. Amer.* 27:1240-1245, October 1947.
21. Williamson, H.O., and McIver, F.A., Sarcoma Botryoides of the Cervix, Treated by Vaginal Hysterectomy and Subtotal Vaginectomy, *Obstet. Gynec.* 31:689-693, May 1968.

AMA Publishes Pamphlet on American MDs

The AMA has recently put out a new pamphlet entitled "The AMA and the American Doctor: Sharing a Common Goal." It is available by writing Dept. DW American Medical Association, 535 N. Dearborn, Chicago, Ill. 60610.

A telephone consultation service exclusively for physicians

WARM LINE

clinical management/ drug abuse crises

Practicing physicians can expect to be confronted at almost any time with a medical crisis related to the misuse of drug substances. Increasing numbers of people are misusing drugs and a dramatic increase in the number of drug-related medical crises has been noted during the past several years.

Although much information on this subject has been disseminated, the need for practical advice on basic clinical management of these crises has become greater.

Four physicians, each of whom has had extensive practice experience in dealing with drug abuse problems, have created a series of three-minute audiotapes detailing basic medical approaches to the most frequently encountered drug abuse crises.

Dr. David E. Smith is Director of the Haight-Ashbury Medical Clinic in San Francisco, California, and Assistant Clinical Professor of Toxicology, University of California Medical Center at San Francisco.

Dr. William Abruzzi was Medical Director of both the Woodstock and Powder Ridge Rock Festivals and is currently the College Physician, State University of New York at New Paltz, New York.

Dr. Edward C. Senay is the Director of Clinical Research for the Illinois Drug Abuse Program and Associate Professor of Psychiatry at the University of Chicago-Pritzker School of Medicine, Chicago, Illinois.

Dr. J. Thomas Payte is the Director of the San Antonio Free Clinic, and Adjunct Instructor in Clinical Pharmacology, University of Texas Medical School at San Antonio.

Their taped discussions are on automatic telephone equipment for utilization at all times. The opinions given regarding treatment modalities are those of the physician speaking.

Amphetamines	**Dr. David E. Smith**
Hallucinogens	**Dr. William Abruzzi**
Opiates	**Dr. Edward C. Senay**
Barbiturates	**Dr. J. Thomas Payte**

For further information contact:

Department of Professional Services
CM/DAC
Roche Laboratories
Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110



surgical grand rounds

Edited by John M. Beal, M.D.

Surgical Grand Rounds are held weekly on Tuesday at 5 p.m. in the Offield Auditorium at Passavant Memorial Hospital. Patient presentations from Passavant, Chicago Wesley Memorial and the Veterans Administration Research Hospitals form the basis of the discussions. This case report was part of the Surgical Grand Rounds of June 8, 1971.

Toxic Goiter and Pregnancy

Case Report:

Dr. Robert Davis: A 24-year-old white female was in apparent good health until approximately six months prior to admission, when she noted the gradual onset of dizziness on exertion, ankle edema, and nocturia. In addition, she noted increasing muscular weakness and puffiness of her face. Approximately one week prior to admission there was palpitation, sweating, and heat intolerance. Her menstrual periods had been irregular. She denied loss of hair, diarrhea, change in psyche, or increased anxiety. Additionally, over this six month period, she noted a 30 pound weight gain with a marked increase in her appetite. Past history revealed that the patient had an episode of rheumatic fever in 1965. Her only medication was birth control pills which she had taken from June of 1970 until 5 months before admission.

Physical examination: pulse was 120 with bilateral bounding pulses. She appeared to be an anxious, hyperactive white female. Her hair was fine and silky, her skin soft, smooth, warm, and moist. A slight lid lag was present. The thyroid was diffusely enlarged. The right lobe was slightly larger than the left. There were no palpable thrills or bruits over the thyroid. Chest was clear, and heart sounds were normal. There was a grade three systolic murmur heard along the left sternum border. Examination of the abdomen was within normal limits. She had slight

Toxic Goiter and Pregnancy

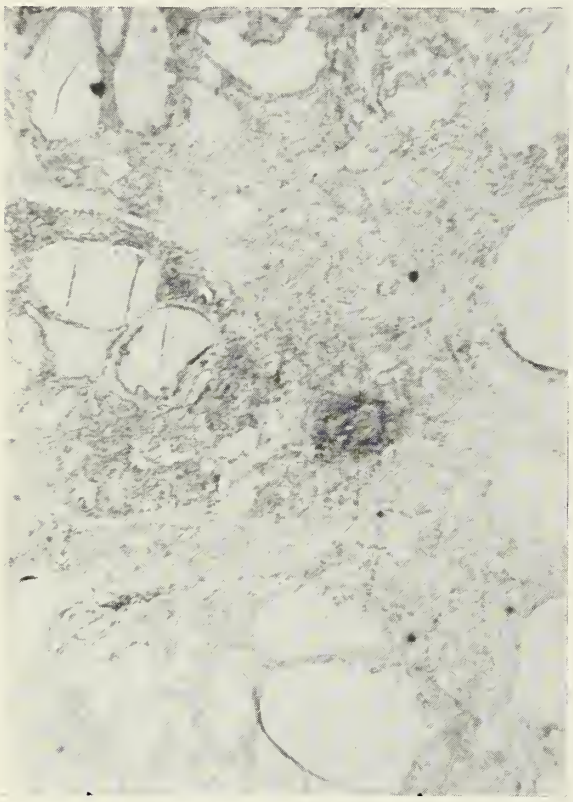


Figure 1. The thyroid follicles vary in size and are well filled with colloid.

pitting edema of the ankles. She had bilateral equal, deep tendon reflexes. Marked muscular weakness of her lower extremities was detected.

Laboratory data: Blood count and urinalysis were within normal limits. Thyroid function studies demonstrated a retention of radioactive iodine uptake with 71% retention, 50% markedly elevated. The cholesterol level was low. A diagnosis of Graves' disease was made and propylthiouracil was administered. She was discharged for approximately a month, and then re-admitted for subtotal thyroidectomy, after approximately a month and a half of anti-thyroid therapy and 10 days of iodine solution prior to admission. At the time of the second admission, the patient was clinically authyroid, but the thyroid gland was unchanged in size. Upon review systems, it was noted the patient was two weeks overdue for her menstrual period, and so a pregnancy test was performed which was positive. (A pregnancy test on her previous admission was negative.) Subtotal thyroidectomy was selected as the indicated therapy for the hyperthyroid state and was performed with an uneventful recovery.

Dr. Joseph Sherrick: The specimen received consisted of a portion of thyroid, which weighed 65 gms, and was lobulated and red. On microscopic examination (Figure 1) the thyroid tissue consisted of small follicles alternating with distended follicles, well filled with colloid. Lymphoid follicles, like the one seen in the center of Figure 1, were scattered through the sections. The follicles showed peripheral vacuolization of the colloid and in Figure 2, one sees some follicles well filled; probably the result of iodine treatment. The papillary infolding of the follicular epithelium is indicative of hyperplasia. Additional evidence of hyperplasia as modified by thiouracil treatment is seen in Figure 3 where the follicles are small, crowded together, do not contain colloid, and are lined by tall columnar epithelial cells which show nuclear variation and occasional mitotic figures. These pathological changes are characteristic of hyperplasia of the thyroid, modified by iodine and thiouracil treatment.

Dr. John Beal: Dr. Hines, will you discuss the problem as seen by the surgeon?

Dr. James Hines: First, I think most of us know that patients with Graves' disease rarely become pregnant. Second, this girl became toxic and gained 40 pounds. She's had an insatiable appetite and in spite of the fact that while most patients with toxic goiters loose, this girl gained some 30-40 pounds. Perhaps this is due to becoming pregnant during this time.

The therapy was directed to both the mother and the fetus. During pregnancy and delivery, these patients can go into a thyroid storm. Secondly, of course, is the effect on the fetus. The toxic goiter is bad for the pregnant fetus as the anti-thyroid drugs can suppress the fetal thyroid and result in cretinism. So, we had the health of the mother and the fetus to consider. We chose to do a subtotal thyroidectomy at about two months gestation and so far she has done well.

Dr. Norbert Freinkel: Although our section did not see this patient during her hospitalization, it may be profitable to use the history of her illness and subsequent course for a more

generalized consideration of Graves' Disease during pregnancy. Towards this objective, I should like to address myself to four questions: Firstly, what is normal thyroid physiology and how does it form the basis for clinical tests of thyroid function? Secondly, how does pregnancy modify iodine economy and thereby complicate conventional diagnostic procedures? Thirdly, how do we treat Graves' Disease in non-gravid women of child-bearing age? Finally, how does pregnancy alter our approach to therapy?

With regard to the first question, let us consider normal iodine metabolism. Ionic iodide, derived exogenously from the diet or endogenously from the breakdown of organic iodinated compounds (in the thyroid or the periphery) is distributed in a volume of the body waters approximating extracellular fluid, i.e., the "iodide space." Two sites compete for the irreversible removal of iodide from this "space": the thyroid and the kidney. Thyroidal and renal rates of iodide clearance reflect this competition. Under ordinary circumstances, the magnitude of thyroidal iodide clearance is delimited by the amount of iodide that the gland needs for adequate hormogenesis. The accumulated iodide is employed for oxidative iodination of tyrosine (and histidine) residues within the stored thyroglobulin of the thyroid gland. A constant fraction of stored thyroglobulin is subjected to proteolysis within the gland per unit time and the liberated thyroid hormones (thyroxin T_4, and triiodothyronine, T_3) enter into the circulation. Here they become associated with plasma proteins which possess varying degrees of binding affinities: thyroxine-binding globulin (TBG) and thyroxine-binding prealbumin (TBPA) and albumin. They circulate as protein-bound iodine in the form of hormone transport protein complexes. Hormonal effects upon tissues are mediate via that proportion of the circulating thyroid hormone which is not complexed to transport protein but exists instead in unbound or "free" form. "Free" hormones associate with tissue receptor sites and effect characteristic actions. Within the central nervous system, one of the tissues sensitive to this impact of thyroid hormone is the anterior pituitary. Delivery of thyroid hormone to the pituitary determines the adenohypophyseal elaboration of Thyroid-Stimulating Hormone (TSH) via direct action of thyroid hormone upon cells which make TSH (i.e., the "thyrotrophs") or by modulating the responsiveness of these cells to a tonic perfusion with Thyrotropin Releasing Hormone (TRH) from the hypothalamus. The secreted TSH in turn acts upon the thyroid gland to regulate its general metabolism and growth and its more specific formation, turnover, and release of thyroid hormone. Thus, a feed-back cycle is established wherein the adequacy of delivery of thyroid hormone to the periphery "sets the pace." One can postulate that the feed-back cycle works most effectively because the anterior pituitary may be slightly more sensitive to the adequacy or inadequacy of thyroid hormone than any other structure in the periphery.

Clinically, we can measure every aspect of this cycle: We use the "uptake" of radioactive iodide by the thyroid gland *in vivo* as an index of how hard the gland is working to "clear" iodide from the "iodide space." We utilize the thyroidal "scan" to visualize the portions of the gland that have accumulated iodinated thyroglobulin. We use the measurement of PBI or T_4 as an index of the total concentration of thyroid hormone in the circulation. The finding of significant discrepancies between PBI and T_4 (i.e., differences greater than 1-2 ug%) indicates that the thyroid gland has released pathological amounts of macromolecules into the circulation

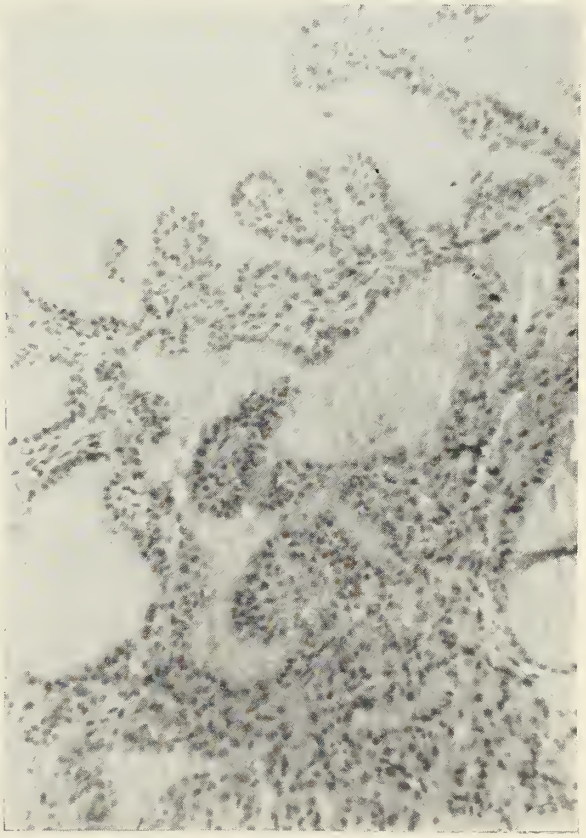


Figure 2. Peripheral vacuolization of the colloid is a prominent feature.

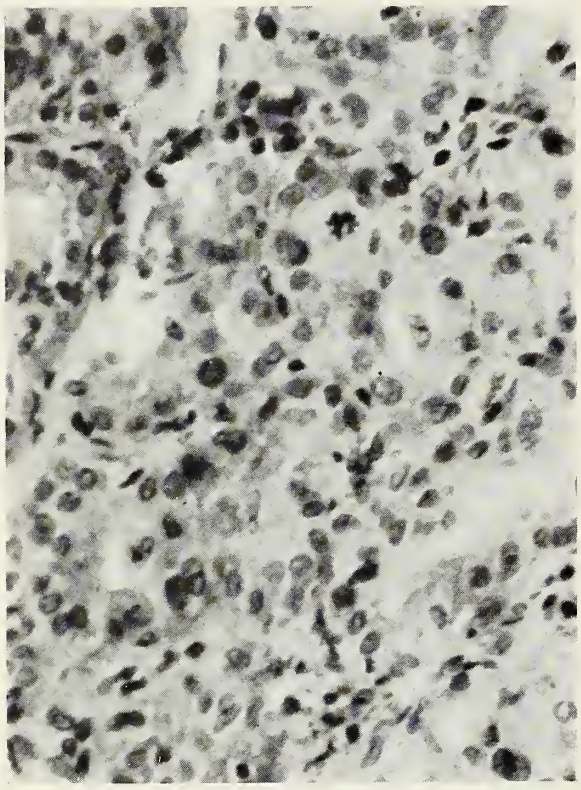


Figure 3. The small follicles, lined by columnar epithelial cells, was present elsewhere in the gland.

(e.g., thyroglobulin, iodoproteins, iodoalbumins) since products of normal hormonogenesis other than T_4 (e.g. T_3) are removed too rapidly to make meaningful contributions to total PBI. Immunoassay or gas chromatography may be employed to estimate T_3 on a research basis and a variety of procedures are available to qualify "free" T_4 and the binding capacities of the individual thyroid hormone-binding proteins. However, for clinical purposes, we rely on *in vitro* resin "uptake" as an inferential index of total circulating hormone and of the proportion that exists in "free" form. Finally, we depend on such "work horses" as BMR and plasma cholesterol to tell us about the adequacy of the impact of the hormone upon tissues in the periphery. Recently we have been able to refine that potentiality by being able to measure plasma TSH directly by immunoassay in several laboratories, including our own.

Great polemics have been addressed to the question of what constitutes "the best single test of thyroid function." I have tried to indicate that there is no simplistic answer. In uncomplicated circumstances, any single test may suffice. Where problems exist, several may be necessary. Each test measures a separate aspect of an integrated physiological loop. As such, each provides supplemental rather than reduplicative information, and interpretive skill and sophistication presupposes an understanding of the physiology upon which each is based.

Pregnancy constitutes one such complicated situation. How does gestation modify iodine homeostasis? During gestation, glomerular filtration rate increases so that the kidney can compete more effectively with the thyroid for removal of ionic iodide from the "iodide space." In addition there is a greater loss of iodide into the developing fetus. Hence, the thyroid has to "work" harder to clear a normal amount of iodide from the "iodide space" for hormonogenesis. A limited number of I_{131} uptakes have been performed in pregnancy (although more extensive studies have been performed with the shorter-lived isotope, I_{132}). These indicate that "uptakes" of radioactive iodine by the thyroid gland are increased in pregnancy. Total circulating thyroid hormone is increased also as estimated by PBI or measurement of T_4. However, this is due to a phenomenon which was first described by Dowling, Ingbar, and myself in 1955—that is, an increase in plasma TBG occurring, presumably, as a consequence of estrogen action. Thus, a greater proportion of the circulating thyroid hormone is bound to protein and total T_4 must be augmented in order to preserve a normal amount of "free" thyroxine in the circulation. This has been recently corroborated directly in several laboratories and it would appear that the thyroid gland need not work any harder to preserve a normal "free" thyroxine once a new equilibrium has been established to compensate for the increase in TBG. Clearly, however, until this equilibrium is established, the thyroid gland has to put out an increased amount of hormone for a transitory interval.

What about the impact of thyroid hormone on tissues? In the latter half of pregnancy, the BMR rises as the conceptus increases its contribution to total oxygen consumption. However, this does not appear to be due to augmented flux of thyroid hormone. Direct estimates have indicated that TSH is within the normal range throughout pregnancy. Recently some placental TSH has been described. This is a material

which reacts best to antiserum to bovine TSH but it is uncertain whether it exerts any quantitatively meaningful role in gestational thyroid economy.

Thus, in summary, the thyroid is slightly enlarged in normal pregnancy and working harder to secure an adequate amount of substrate for hormonogenesis (i.e., ionic iodide). TBG is increased so that an elevated PBI or T_4 must be maintained in order to preserve a normal concentration of "free" hormone. As a reflection of the increased TBG, resin "uptake" is normally reduced during pregnancy. BMR rises in late pregnancy but this is ascribable to intrauterine oxidative demands rather than any overall change of maternal thyroid hormone metabolism.

What about fetal thyroid function? It would appear that the fetus has a relatively independent thyroid-pituitary axis. Normally the thyroid in a human fetus begins to function at about 12-16 weeks of age. Thus, in the lady under consideration today, the fetal thyroid was as yet inoperative since the surgery was performed in the first month of pregnancy. Fetal elaboration of TSH proceeds in accord with fetal hormone demands and a separate feed-back system is established since TSH does not appear to cross the placenta in either direction and transplacental equilibration of T_3 and/or T_4 appears to be relatively slow. (Definitive kinetics remain to be established and it is doubtful whether there is any meaningful limitation to the transplacental exchange of "free" hormones. The limiting factor instead appears to be the rate of perfusion of the placenta.)

How does Graves' Disease alter the physiological "feed-back" between the demands of the periphery for hormone and the synthesis and release of hormone by the gland? In brief, it would appear that the periphery is no longer "setting the pace." Instead, glandular elaboration of hormone proceeds without "feed-back" regulation, and, in the process, the release of hormone may be too much, adequate, or, on rare occasions, even too little for the periphery. Clinical thyrotoxicosis becomes manifest when the impact of hormone on the tissues is pharmacological and substantially exceeds physiological requirements. As a more subtle expression, the adenohypophyseal elaboration of TSH becomes obtunded and TSH can no longer be demonstrated in the circulation. As yet, no one knows for certain what is "driving" this autonomous function of the gland. An immunoglobulin called "long-acting thyroid stimulator" (LATS) has been demonstrated in the circulation of a sizable proportion of patients with Graves' Disease. However, it is not invariably present and most authorities today do not believe that LATS is etiologically responsible for the autonomy of the Graves' Disease thyroid gland. Most also feel that LATS is not responsible for those aspects of Graves' Disease, such as ophthalmopathy, which can occur even in the absence of thyrotoxicosis.

How then, can one treat Graves' Disease with coexisting thyrotoxicosis? It would be nice to attack the underlying etiology but this is impossible since the etiology is unknown. Alternatively, it might be desirable to diminish the impact of the hormone upon the tissues. Once again, there is no established mechanism by which we can achieve this, although some of the actions of the hormone can be blunted by Rauwolfia alkaloids or autonomic "blocking" agents. Thus, in terms of feasibility, we are left with approaches wherein we attempt to interrupt the excessive synthesis of hormone within the thyroid gland. We can do this by reducing absolute thyroidal mass via surgery or radioactive iodine, or by reducing the function per unit mass by introducing chemical blockade with anti-thyroid drugs. In this patient's age group, many, including myself, would not use radioactive iodine. The coexistence of pregnancy affects our deliberations concerning the other two potential therapies, surgery vis-a-vis anti-thyroid drugs.

Ordinarily, in a female of this age, we would probably try medical management with the thiourylene series of drugs because we can anticipate that 40 to 50% of them will enter remission during a 9 to 12 month course of such treatment. However, pregnancy complicates matters. As we mentioned just a few minutes ago, the fetus elaborates TSH independent of the mother and there seems to be no evidence for transplacental TSH exchange. Indeed, one can get goitrogenecity as early as the fifth month in the fetus so that the fetal hypothalamic-pituitary axis must be established already at that time. Moreover, as we also discussed above, the net traffic for thyroid hormone across the placenta appears to be limited even though "free" hormone exchanges freely. This seeming anomaly is easily understood. Assuming that approximately 0.1% of the total PBI exists in the "free" form and that placental blood flow equals about one liter per minute, the potential delivery of "free" hormone must lag behind the fetal demands since the fetus appears to be using thyroxine at a

(Continued on page 76)

HEALTH SCIENCES LIBRARY
UNIVERSITY OF MARYLAND
BALTIMORE

By Robert R. Hartman, M.D./Jacksonville

Maternal death study

Case report No. 5

The fifth in a series of case reports

ONE OF THE FUNCTIONS of the ISMS Committee on Maternal Welfare is to analyze the causes of deaths in Illinois mothers and to determine, if possible, what alterations in management and treatment could have prevented any of these deaths. Each month a case will be presented and discussed in an attempt to promote more modern methods of obstetrical management. It is with extreme gratitude that the assistance of the Illinois Department of Public Health is acknowledged. Without their initial collection and preparation of the cases and protocols these studies would be very limited.

Case Report:

This 35-year-old non-white para V gravida VII was admitted to the hospital with the history of recent rupture of the membranes, not in active labor. About 6 weeks prior to this admission she had been hospitalized for several days because of an episode of uterine bleeding interpreted by the attending physician as a definite separation of the margin of the placenta. There had been no bleeding in the interim, and X-ray and placentography were reported as normal. A "slow pitocin drip" was used to stimulate labor and during the first stage, bleeding was reported as more than normal show. Delivery of the fetus was accompanied without difficulty, however, about one hour after institution of the induction.

Following the delivery of a placenta with evidence of old bleeding, the patient passed a very large recent clot. The oxytocic had been discontinued before moving the patient to the delivery room and the patient was treated with intravenous methergine, 10 units of pitocin, and uterine massage. When the uterus failed to "clamp down," an intrauterine pack two inches in width and five yards in length was inserted into the cavity of the uterus. Bleeding continued and consultation was requested approximately 45 minutes after delivery. The consultant removed the pack and inserted a second one, but the patient shortly thereafter bled through this pack as well. The patient was taken to surgery for hysterectomy, where before anesthesia could be started, she was noted to have no heart beat nor pulse. Total lapsed time from delivery to death approximately 2 hours and 15 minutes.

Autopsy showed acute and massive uterine hemorrhage with interstitial hemorrhage and early tearing and hematoma of the cervix. The fibrindex level was reported as 23 seconds, normal 60 seconds.

Your committee was forced to accept this death as being directly obstetric from hemorrhage. Since the record was unclear as to many details, some questions were raised relative to management:

Number one, no mention was made as to pelvic findings before induction. Further, no definition of slow pitocin drip was given. While there was no objection to an attempt at stimulated labor with a patient with ruptured membranes or with partial separation of the placenta, too rapid efforts to deliver the patient may be traumatic. The grand multipara is particularly susceptible to uterine rupture and some question was raised regarding the significance of the diagnosis of interstitial uterine hemorrhage with

(Continued on page 60)

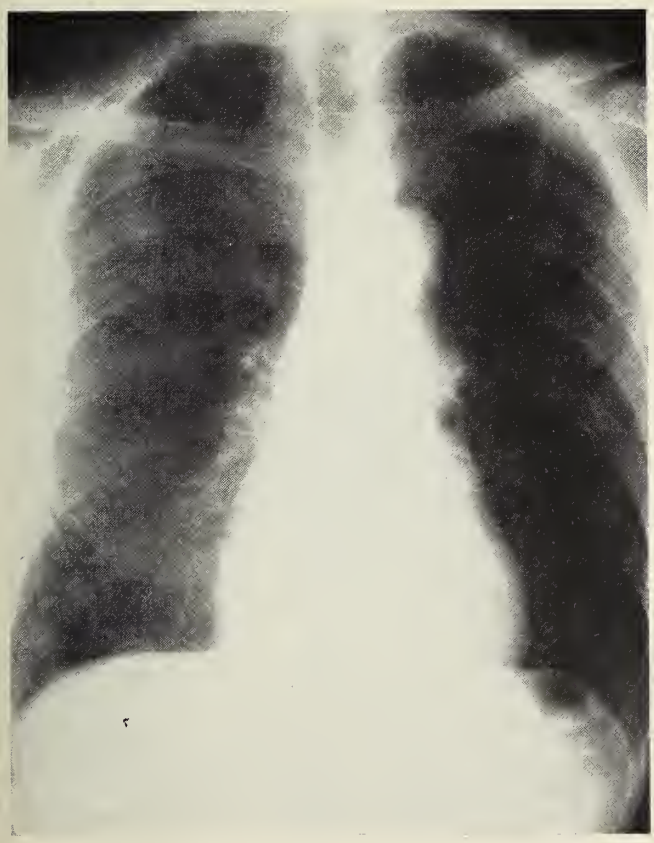
the view box

Leon Love, M.D./Chairman/Department of Radiology
Loyola University Stritch School of Medicine

This 55 year old male had a routine chest X-ray taken. Blood pressure was 160/90. There was a short ejection systolic murmur over the precordium felt to be "innocent".

What's your diagnosis?

Figure 1.



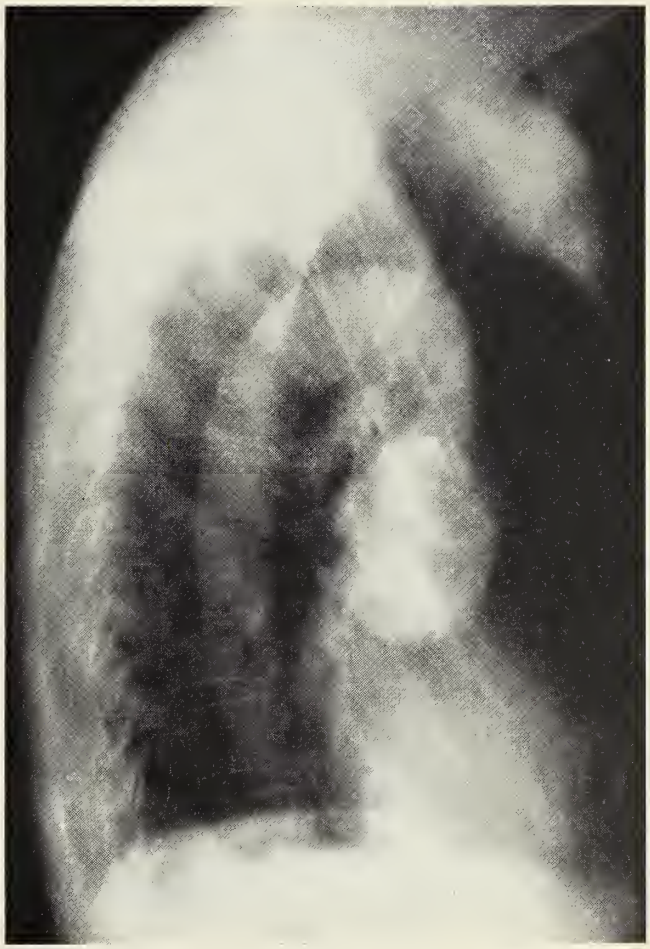


Figure 2.

(Diagnosis on page 60)

FOR the patient and for the physician, the treatment of acute depression is usually a gratifying experience. Clinically, depression covers a broad spectrum of moods and behavior which ranges from the disappointment and sadness of normal life to the bizarre self-destructive acts of psychotic melancholics. A widely prevalent clinical disorder, it may be the most commonly treated psychiatric syndrome among adults. Moreover, a wide variety of treatments with demonstrated efficacy are available. In addition to reviewing the three classes of specific antidepressants—the psychomotor stimulants, monoamine oxidase inhibitors, and tricyclic antidepressants—I will review the place of phenothiazine, sedative-hypnotics, and minor tranquilizers in the treatment of depression, and discuss the treatment of some of the complications of depression.

Drugs In The Treatment Of Depression

By Gerald L. Klerman, M.D.

Psychomotor Stimulants

The psychomotor stimulants, of which the amphetamines are the prototypic compounds, are currently much less important in the treatment of depression than they had been previously. Amphetamine, dextroamphetamine, methylphenidate and related drugs will increase alertness and produce elevation of mood, but these effects are relatively weak, often disappearing after a few days. The recent controlled trials on the amphetamines have cast doubt as to their effectiveness over placebo for the vast majority of patients.

Since many patients also experience an increase in anxiety, tension, and irritability with the amphetamines, barbiturates often have been prescribed as adjunctive treatment and several amphetamine-barbiturate combinations are marketed. Pharmacological studies in animals and in normal humans indicate that amphetamine-barbiturate combinations have synergistic effects which—in humans—produce greater elation and less interference with normal performance than are produced by either drug alone. These effects, however, are of limited clinical value in most depressions.

The principal objection to the use of the amphetamines is the occurrence of abuse and dependence. Tolerance rapidly develops and the dose is often increased by the patient. Toxic psychoses resembling paranoid states may occur. A true withdrawal syndrome, which includes fatigue, hyposomnalism, and increased REM sleep, has been documented.

Monoamine Oxidase (MAO) Inhibitors

The MAO inhibitors are prescribed less today than they were a decade ago. Physicians are hesitant to prescribe these effective drugs because of their adverse effects. The pendulum, however, may have swung too far—many patients that might benefit from the MAO inhibitors do not receive them.

Based on chemical structure, the MAO inhibitors are divided into two sub-groups. *The hydrazines,* of which phenelzine (Nardil), isocarboxazid (Marplan) and nialamide (Niamid) are marketed in the United States. Two hydrazines of demonstrated efficacy, iproniazid (Marsilid) and pheniprazine (Catron), were removed from the market because of liver complications and other adverse effects. The nonhydrazines include tranylcypramine (Parnate) and pargyline

(Eutonyl), which is also used for hypertension.

All of these drugs inhibit MAO in animal brains. In patients, correlation has been demonstrated between the pharmacologically induced reduction in MAO activity and improvement in the patient's mood and clinical symptoms. While their pharmacologic actions are of great importance for research and theory, controlled comparisons indicate that the MAO inhibitors are less effective than the tricyclic derivatives. A number of physicians maintain that certain patients respond specifically to MAO inhibitors. Therefore, before concluding that a patient is unresponsive to drug treatment, a trial with an MAO inhibitor is indicated.

Adverse reactions are more common with the MAO inhibitors than with the tricyclic series. Dry mouth and other anticholinergic effects occur, and hypotension is commonly found with higher doses. With tranylcypramine, amphetamine-like effects may occur. The most serious problem with the MAO inhibitors arises from the possibility of acute hepatic damage, which led to the withdrawal of iproniazid and pheniprazine from the market. The adverse effects which have caused the most difficulty have resulted from toxic interactions with other chemical substances. The dietary precipitants include yeast, certain beans, pickled herring, chocolate, milk and cream products, and various wines and cheeses. Hypertensive crises were noted in the early trials of iproniazid in tuberculous patients and even more frequently with the introduction of tranylcypramine (Parnate). Combinations of MAO inhibitors with a tricyclic antidepressant, or their administration less than one week after the tricyclic has been discontinued, may result in restlessness and even coma. Because of these adverse effects and the limited range of efficacy, the MAO inhibitors are used mainly for patients who have not responded to the tricyclic antidepressants.

Tricyclic Antidepressants

The tricyclic antidepressants are currently the most widely used and generally the most effective antidepressants. Imipramine (Tofranil) is the parent compound of the prototypic series, which also includes desipramine (Norpramin, Pertofrane). Another related group is derived from the dibenzocycloheptene nucleus, and includes amitriptyline (Elavil), nortriptyline (Aventyl), and protriptyline (Vivactil). Recently, a third type of tricyclic derivative, doxapin (Sinequan), has been marketed. Their tricyclic structure is similar to the nuclei of the phenothiazines and thioxanthenes. All three chemical groups share similar pharmacologic and clinical actions.

In normal human subjects, the tricyclic drugs induce mildly sedative effects similar to the phenothiazines. Their antidepressant effect is probably related to their capacity to potentiate the CNS actions of norepinephrine. These drugs potentiate the peripheral effects of catecholamines, reverse the reserpine syndrome in animals, potentiate the central effects of amphetamines, and block the re-uptake of norepinephrine at the pre-synaptic membrane.

Imipramine and amitriptyline, the most widely prescribed tricyclic antidepressants, have been extensively evaluated in controlled studies. Other tricyclics also have proven to be effective. Desipramine and nortriptyline, the desmethylated derivatives of imipramine and amitriptyline, have more potent norepinephrine-potentiating effects in animals than their parent compounds. Researchers have suggested that the desmethylated compounds were the pharmacologically active metabolites. This hypothesis, however, has not been borne out clinically, and the desmethylated compounds are not clinically more effective nor more rapid in action. Perhaps more efficacious tricyclic compounds will be found among the new tricyclics under evaluation.

The dose range of the tricyclic compounds is wide. It is possible to start patients at low dose—20-40 mgm per day—of imipramine or its equivalent, and gradually build up to 300 mgm per day. Therapeutic response may require from one to two weeks of treatment and may not be maximal until the third or fourth week. In controlled trials, drug-placebo differences first appeared at about two weeks and became maximal at about 3-4 weeks. If clinical response has not occurred within 4-6 weeks at an adequate and individualized dose, continuation of the drug usually is not worthwhile and an alternative treatment should be considered. By adequate dose, I mean the dose arrived at by gradually raising the total

GERALD L. KLERMAN, M.D., is professor of Psychiatry at the Harvard Medical School. He is also superintendent of the Erich Lindemann Mental Health Center. Dr. Klerman is on the advisory committee on Neuropharmacology of the Food and Drug Administration, and is consultant of the Medical Letter of Drug and Therapeutic Information, Inc.



daily dose until the patient develops discomforting autonomic effects or the therapeutically desirable response; hopefully the latter will emerge first.

The optimal duration of treatment has not been clearly demonstrated. These drugs should not be discontinued rapidly. Some period of gradual withdrawal is considered desirable, since symptoms of nausea, vomiting, malaise and muscular pains occasionally occur as part of a mild withdrawal reaction. Currently, clinical practice is to withdraw the drug slowly three or so months after remission and observe the patient's reactions.

Although the tricyclic drugs are relatively safe, a variety of adverse effects, mostly minor, occur—particularly with doses above 250-300 mgm per day. The most common adverse effects are due to autonomic actions: dry mouth, increased sweating, difficulty in visual accommodation, postural hypotension, and urinary retention. These effects are dose-related and are more common in the elderly. Rare instances of jaundice and blood dyscrasia also have been observed.

Tranquilizers and Sedatives

In clinical practice many depressive patients also receive tranquilizing or sedative compounds such as phenothiazines, meprobamate, or diazepines—either alone or in combination with antidepressant agents. This therapeutic regimen is usually aimed at symptoms such as anxiety, insomnia, restlessness, agitation, irritability, and tension, which are frequent components of the depressive state. When such symptoms are the predominant manifestations or presenting complaints of the depression, diagnosis may be obscured and tranquilizers are often prescribed. There are two other indications for the use of sedatives or tranquilizers in depression: for patients with schizophrenic, delusional or paranoid features, and for patients with previous history of psychosis who often do poorly on antidepressants alone. Combined treatment with a phenothiazine, however, may be effective, and various sedatives and tranquilizers alone may have beneficial value. The same cannot be said of all antipsychotic drugs, of which butyrophenones and the Rauwolfia derivatives aggravate depression.

A number of controlled trials have documented the efficacy of the phenothiazines in certain depressed patients, particularly the trials initiated by Fink, et al; Paykel and co-workers; and the influential studies by Overall, Hollister, and the V.A. group. Clinicians are developing patient classifications which will allow for prediction of differential response to drugs. Imipramine and the tricyclic derivatives are superior in "retarded" depressives, while thioridazine and the phenothiazines may be of greater value in active and psychotic depressions. There is considerable overlap, however, among the actions of the phenothiazines, the thioxanthenes and the tricyclic drugs.

Electroconvulsive Therapy (ECT)

Electroconvulsive therapy has been used for 30 years. A carefully controlled pulse of electrical energy is passed through the head, causing an initial tonic contraction followed rapidly by a generalized clonic convulsion. The current preferred technique is to anesthetize the patient with a rapid-acting barbiturate and modify the muscular effects by giving short-acting muscle relaxants. It has been shown that the convulsion is necessary for therapeutic effect. The immediate post-treatment effects are confusion, headache, and muscular pains. Although the procedure is relatively safe, with a risk no greater than that of a minor anesthesia, it should be prescribed with care. While it usually is given in a hospital setting with an anesthesiologist in attendance, it can be given to selected outpatients.

The major adverse effect is memory loss which, while rarely severe, is distressing to the patient. The effect usually lasts only a week or two, and can be ameliorated by restricting the frequency of convulsions to not more than three per week and by limiting to under 12-15 the total number of treatments in any course. An average of 7-10 treatments is usually sufficient. In those who respond, some brightening of mood is obvious after four treatments. ECT tends to act more rapidly than drugs and is also more effective—good response being shown by about 80 percent of patients.

Absolute contraindications are few, but the possibility of memory impairment must be carefully considered when the patient's occupation depends upon his mental ability. The danger of memory loss also severely limits the reuse of ECT for patients who have had a relapse. It is recommended that there be an interval of at least 4 months between courses, and an even

longer interval if repeated courses already have been given.

While it is impossible to predict accurately which patients will respond, experience indicates that favorable results will be obtained with middle aged and older patients, those who have had a previously stable personality adjustment, or those with a "psychotic" or "endogenous" depression. ECT remains the treatment of choice for the severely symptomatic, the actively suicidal, and for those patients whose medical condition contraindicates the use of drugs.

Mania

Mania is a rare but important complication of depression. Less than ten percent of patients with depressions have a history of mania. Yet, when it does occur, manic-depressive psychosis is dramatic. Depressed patients should be carefully watched for impending signs of overactivity, garrulousness, and excessive cheerfulness, particularly when treated with high doses of drugs. If there is evidence that the patient is becoming "high," antidepressant drug therapy should be discontinued. If mania is severe and does not remit within a few days, the patient must be considered a candidate for intensive treatment—best accomplished in a hospital.

There are two effective groups of compounds for the management of the symptomatic state: the antipsychotic drugs, of which the phenothiazines and the butyrophenones are most effective, and lithium, which have value for prophylaxis.

Relapse, Recurrence, and Chronicity

Depressive illness tends to recur in discrete episodes throughout life and the patient is relatively "normal" during the intervals. Recurrences usually respond to the treatment used successfully in the past. For many patients, maintenance treatment with an antidepressant drug will prevent relapse and reduce the likelihood of recurrence. Sometimes, the patient relapses while taking antidepressant drugs, which is an indication to increase the dose, or if this fails, to change treatment.

While most depressions are acute and respond well to treatment, there are patients whose illness may become chronic. Some patients have a clearly defined illness which has not improved. A decision must be made as to whether they can function in the community with drugs, support, and social help, or whether long-term hospital care is necessary. Also, there are patients subjected to long-term stress beyond their capacity. Another group, merging with the above ones, are those patients with a chronic neurotic personality disorder. Their complaints of depression seem more a part of their life style than part of a clearly delineated depressive illness. For these patients, drugs are often said to be contraindicated because of the high risk of abuse and dependence. However, in these chronic conditions, any symptomatic alleviation is worthwhile, both for the patient and his family. Therefore, drug treatment, under careful supervision should be attempted.

Conclusions

The most pressing clinical research problem in the use of antidepressant drugs is the need for a rational criterion for their differential on prescription. A common view is that certain patients are specifically responsive to tricyclic drugs, to MAO inhibitors, or to lithium. Patients with depressions corresponding to the endogenous depressive pattern are often regarded as being more responsive to tricyclic compounds, while patients with neurotic and atypical depressions are regarded as being more responsive to MAO inhibitors. Controlled trials indicate the efficacy of tricyclic drugs in depressed patients characterized as endogenous, psychotic, or retarded. Good results with tricyclic agents, however, also have been reported in neurotic depressives and in a group of anxious, phobic patients.

There is a possibility that such specifically responsive sub-groups will be delineated on some other basis, such as a biochemical one, which might be independent of clinical classification. It also is important to remember that ECT is an alternative effective somatic treatment for severe depression, with which drug treatments must be compared. Moreover, there is evidence suggesting familial consistency of response on a genetic basis to drugs of the tricyclic or MAO inhibitor class. In addition there may be a large group of patients in whom there are few differences between drug and placebo, or eliminating that if there are such differences, they may be obscured by other factors.

Deciding Factors

When deciding which treatment to use for a patient, and when evaluating the relative success of treatment, the psychiatrist should be aware of certain salient features of the clinical disorder—especially the variety of symptoms of

(Continued on page 84)



Over-specialization injures health care coverage

May 17, 1972

Dear Doctor Bornemeier:

It's not often that I find myself on the same side of the healthcare issue as a past or current President of the AMA; but I find myself in general agreement with your letter to the editor of the *Illinois Medical Journal* which was published on Page 393 of the April, 1972 issue.

Your analysis of the reasons for the maldistribution problem coincides with the view I have held for some time. I, too, believe that it has been iatrogenically produced by the nature of our medical education process which trains the great majority of our doctors to take care of approximately 20% of the ills which bring people to a doctor and makes them look down their noses at the other 80% for which they are extremely over-trained. We must find ways of attracting students into family practice training, but that will be difficult to do as long as the family practitioner will be low man on the totem pole in the medical hierarchy, both in the medical school and in the hospital.

I wish that I could believe that training 20,000 doctors a year would solve that problem. I don't happen to have as much faith in the power of competition as you seem to; but, now that you and others have begun to define the problem precisely perhaps it will be easier to find the right solutions.

Very truly yours,
James G. Haughton, M.D.
Health and Hospitals Governing
Commission of Cook County

Are midwives practicing medicine?

Dear Editor:

The attempts of the Medical Profession to declare pregnancy a disease and thus enjoin the age old practice of midwifery, have reached a foolish pinnacle in the case of *California Board of Medical Examiners v. Norman Casserly,* midwife. There is no question here of Casserly's competency, nor of the vital social need explicit in his calling. No, the only issue here is that of medical imperialism, i.e. the systematic process by which the medical profession engages in a disreputable system of professional aggrandizement, with complete disregard of either personal or public priorities.

In hopes that you give consideration and airing to this discreditable behavior, I am,,

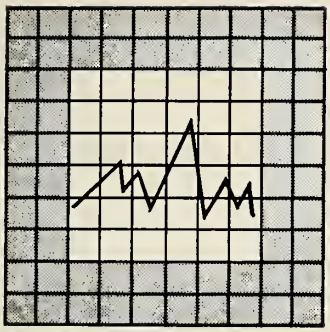
Seth E. Many, M.D.
Cambridge, Mass.

A recent legal case illustrating the controversy over midwifery follows:

Norman Casserly, a California midwife previously enjoined from the practice of his chosen career, was convicted in a California Municipal Court of practicing medicine without a license on Friday, March 3, 1972.

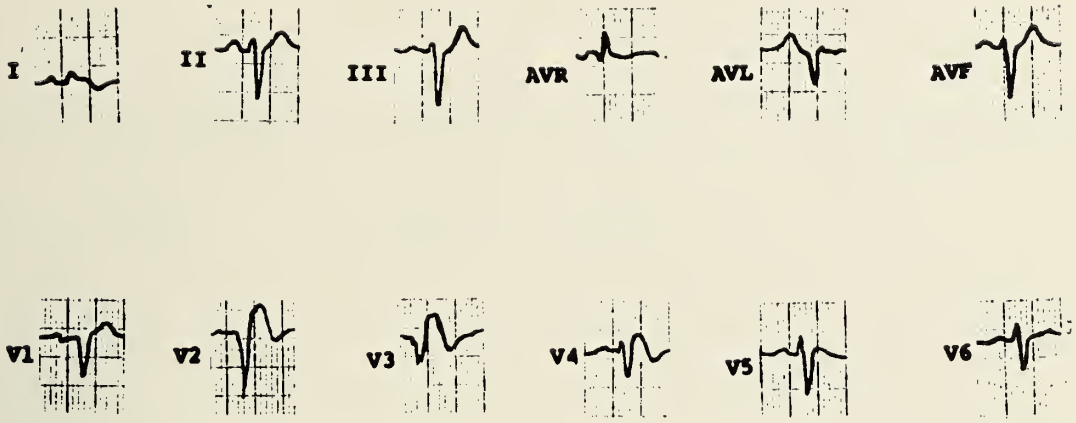
The judge, in his charge to the jury, declared that pregnancy and birth are abnormalities known as "sickness or affliction" and that persons who conclude that there is no need of treatment are engaged in the diagnosis of illness, and hence, the practice of medicine.

Casserly has allegedly home-delivered some 3,500 babies over the past 25 years without complication. Sentencing could carry a $1500 fine and 1½ years in jail. (From the Vile Files of Dr. E. Page 5, March 28, 1972, *Boston After Dark.)*



ekg of the month

John R. Tobin, Jr., M.D., M.S., Rimgaudas Nemickas, M.D., Patrick Scanlon, M.D., John F. Moran, M.D. and James V. Talano, M.D./Section of Cardiology, Loyola University Stritch School of Medicine



This 56-year-old man suffered a myocardial infarction three months ago. Since that time he has had dyspnea on exertion, orthopnea, and occasional paroxysmal nocturnal dyspnea. Two weeks ago he had transient left hemiparesis.

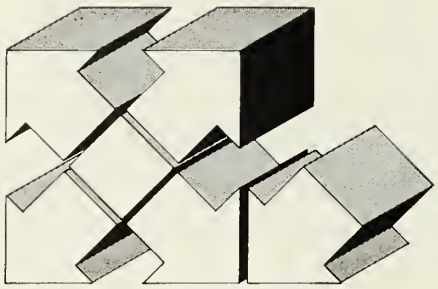
Physical examination reveals basilir rales, a paradoxical impulse medial to the apex, and an S_3 at the apex.

Questions: (One or more of the choices may be correct.)

A) The electrocardiogram suggests:
1. Inferior wall infarction.
2. Anteroseptal infarction.
3. Acute pericarditis.
4. Ventricular aneurysm.
5. All of the above.

B) Regarding this patient:
1. Anticoagulants are indicated.
2. The coronary artery most likely involved is the left anterior descending.
3. Surgery should be considered.
4. Surgery is necessary for all patients with ventricular aneurysm.

(Continued on page 60)



trauma center

By Ronald Lee Nichols, M.D., Haragopal Thadepalli, M.D.,
Sherwood L. Gorbach, M.D./Chicago

Infections Following Abdominal Trauma

Contamination of the abdominal wall and peritoneal cavity with microorganisms occurs as the result of penetrating or blunt visceral trauma. Bacteria may be carried in with the penetrating object (exogenous contamination), or may escape from the viscera after penetration or rupture (endogenous contamination). Endogenous contamination is more important due to the high incidence of peritonitis or intra-abdominal abscess formation which follow its occurrence.

Many factors play a role in the development of clinical infection following contamination of the tissues with bacteria. These include the inherent virulence and growth requirements of the microorganism as well as characteristics of the injury and underlying host factors. (Table I.)

The presence of bacteria within a wound is not synonymous with clinical infection. The differentiation between contamination and a wound infection is made clinically. Laboratory reports only confirm the type of infection. Careful clinical evaluation includes a search for the presence of local signs of wound sepsis (e.g., redness, pain, swelling or exudation), or evidence of systemic infection (chills, fever, toxicity, etc.). A positive culture result without clinical findings is not an infection. *Clostridium perfringens* (gas gangrene bacillus) is more often a superficial contaminant rather than a cause of a wound infection.

I. Normal Microbial Flora

Bacteria that comprise the indigenous microflora of the intestine are potential pathogens. These organisms are separated from the surrounding tissues by the mucous membrane bar-

rier of the bowel. This membrane barrier can be damaged as a result of direct trauma with resultant escape of bacteria.

Great qualitative and quantitative variation in the intestinal microflora exists at different levels of the intestine. Generally speaking, the ileocecal valve acts as an anatomic dividing point separating the luxuriant bacterial growth of the cecum and colon from the small bowel with its relatively lower numbers and types of bacteria.

A. Microflora of the proximal bowel— This upper region, which includes stomach, duodenum, jejunum and proximal ileum, has a sparse microflora consisting chiefly of aerobic or facultative Gram-positive microorganisms, including streptococci, lactobacilli, diphtheroids and fungi. These organisms are found in low concentrations usually less than 10^5 bacteria per ml of intestinal fluid. They originate in the oral cavity and pass down the gastrointestinal tract following meals, resulting in a transient microflora in the proximal intestine. Most bacteria ingested with food are destroyed by gastric acid, and the stomach provides an important barrier to microbial overgrowth. Those bacteria which are carried into the small bowel are generally acid resistant.

B. Microflora of the distal small bowel— The distal ileum harbors a significant resident microflora in most subjects. Tests show concentrations of both aerobes and anaerobes average approximately 10^4-10^5 per ml (10,000-100,000). The appearance of the obligate anaerobe, Bacteroides, is first noted at this level. The distal ileum acts as a transitional zone between the sparse flora of the upper gastrointestinal tract and the luxuriant microbial populations found in the colon.

C. Microflora of the large bowel—Beyond the ileocecal valve a striking difference in the numbers and types of microorganisms is observed. The major forms in the large bowel are anaerobic; the oxygen-sensitive bacteria such as Bacteroides, Bifidobacteria, Clostridia and Peptostreptococci outnumber aerobic strains a thousand times or more (i.e., 10^{11} per gram of anaerobes versus 10^7 per gram of aerobes). Thus, for each *E. coli* cell in the large bowel, there are 1,000 to 10,000 Bacteroides.

The large bowel provides an ideal anaerobic environment with relative stasis and a low oxygen-reduction potential. Parenthetically, an abscess cavity provides similar conditions and it is not suprising that anaerobes are so abundant in surgical infections.

TABLE I

Infection—Balance of Host-Organism factors

CONTAMINATION

HOST	ORGANISM
Extent of tissue necrosis →	← Virulence (toxins, destructive enzymes)
Vascularity of involved tissues	Extent of inoculum
Local immunity (gamma globulin, WBC's)	Growth requirements
Presence of foreign bodies	
Underlying diseases (diabetes, cirrhosis, arteriosclerosis, etc.)	

↓

INFECTION

II. Extent of Abdominal Trauma—Antibiotic Treatment

Penetrating abdominal trauma (knife or gunshot wounds) may cause injury to the specific organ or parts in the trajectory with resultant spillage of bacteria. Blunt abdominal trauma usually causes rupture of solid intra-abdominal organs. Damage to the liver or spleen alone rarely is complicated by intra-abdominal infections. However, combined solid organ injury (liver, spleen, pancreas) with bowel contamination usually leads to serious infections in and around these structures.







The authors of this article are pictured from top to bottom. Ronald Lee Nichols, M.D., is Assistant Professor of Surgery, The Abraham Lincoln School of Medicine, University of Illinois, Chicago.

Haragopal Thadepalli, M.D., is Fellow in Infectious Diseases at Cook County Hospital, Chicago.

Sherwood L. Gorbach, M.D., is Chief, Department of Infectious Diseases, Cook County Hospital, and Associate Professor of Medicine and Microbiology, The Abraham Lincoln School of Medicine, University of Illinois, Chicago.

TABLE II

Recommended Antibiotic Agents—Abdominal Trauma

Type of Injury	Agent	Dose
Exogenous Contamination		
Penetrating injury abdominal wall	None	
Penetrating injury abdominal wall and peritoneal cavity (minimal contamination)	None	
Penetrating injury abdominal wall and peritoneal cavity (moderate to massive contamination)	Cephalothin (Keflin) Kanamycin (Kantrex)	2 grams IV q 6 hrs 0.5 gram IM q 12 hrs
Penetrating injury abdominal wall and peritoneal cavity with penetration into solid viscus (liver-spleen) if significant delay in surgery or evidence of contamination is present	Cephalothin (Keflin) Kanamycin (Kantrex)	2 grams IV q 6 hrs 0.5 gram IM q 12 hrs
Endogenous Contamination		
Penetrating injury abdominal wall and peritoneal cavity with penetration into stomach, duodenum, jejunum, or proximal ileum	Cephalothin (Keflin) Kanamycin (Kantrex)	2 grams IV q 6 hrs 0.5 gram IM q 12 hrs
Penetrating injury abdominal wall and peritoneal cavity with penetration into distal ileum or colon	Lincomycin (Lincocin) Kanamycin (Kantrex) *OR* Chloramphenicol (Chloromycetin) Kanamycin (Kantrex)	600 mgs. IV q 6 hrs 0.5 gram IM q 12 hrs 1 gram IV q 6 hrs 0.5 gram IM q 12 hrs

A. Penetrating injury limited to the abdominal wall—Most simple stab wounds in the abdominal wall are treated by vigorous cleansing, removal of all foreign bodies and surgical debridement of all devitalized tissues. Adequate hemostasis must be performed in order to prevent hematoma formation, a complication that greatly enhances the chances of wound infection. These wounds should then be packed open and redressed frequently allowing them to heal by secondary intention. Primary closure is recommended only in the case of "clean" wounds treated early and without risk of contamination. Prophylactic antibiotics are not indicated and antibiotics should be given only if late infectious complications occur.

B. Penetrating injury involving abdominal wall and the peritoneal cavity—Simple stab wounds to the abdominal area may not require surgical exploration and antibiotic therapy if there are no clinical signs of peritonitis. Surgical exploration is indicated in all gunshot wounds with questionable clinical findings. If no penetration of the intra-abdominal viscera is found at the time of operation, antibiotic therapy is not necessary. On rare occasions there is evidence of peritonitis in the absence of intestinal injury. This contamination was probably introduced by the penetrating object. In these cases broad spectrum antibiotic coverage should be given parenterally in addition to tetanus prophylaxis. See Table II.

C. Penetrating injury of blunt trauma resulting in disruption of an intra-abdominal viscus—When penetration of the intestine is found at laparotomy, the use of antibiotics should not be considered *prophylactic*, but rather, *active therapy*. The drugs should be begun early and should be tailored specifically to the area of intestinal leakage. A general knowledge of the types of bacteria which inhabit the different levels of intestine has been offered previously and accounts for the antibiotic therapy recommended in Table II.

Danger of infection with anaerobes such as Bacteroides increases with injuries to the distal ileum and colon. Previous reports suggesting that anaerobes seldom produce clinical infection are due to the inability to grow these fastidious organisms in conventional bacteriologic media, e.g., thioglycolate. With improved bacteriologic techniques, Bacteroides and other obligate anaerobes are more commonly recognized in postoperative sepsis following intestinal surgery in both elective and emergent situations. A list of the common anaerobic infecting organisms causing sepsis after emergent surgery for abdominal trauma is given in Table IV.

Adequate parenteral antibiotic therapy must be designed to cover both the aerobic coliforms and also the predominant intestinal anaerobes (Bacteroides). Most broad spectrum antibiotics have little effect on anaerobes, a fact which may explain the frequent development of late abdominal abscesses following conventional antibiotic treatment for penetrating abdominal trauma. Two illustrative cases are now reviewed from the records of the Cook County Hospital Trauma Unit:

Case History I.

G. L., male, age 46, was admitted on November 14, 1971 for a gunshot wound in the abdomen. An exploratory laparotomy was performed and lacerations of the liver, stomach, left kidney and descending colon were found. The lesions of the stomach and liver were repaired, a partial left nephrectomy was done, and a colostomy was performed.

The patient was initially treated with Penicillin (5 million units IV q 6 hours) and chloramphenicol (1 gm IV q 6 hours). While on this therapy, he developed high fever and chills. Blood cultures done on three successive days grew *Bacteroides fragilis*. A wound culture from the incision grew the following bacteria: (1) *Bacteroides fragilis;* (2) *Staphylococcus aureus;* (3) Diphtheroids; (4) *Eubacterium lentum;* and (5) *Pseudomonas aeruginosa.*

The Bacteroides septicemia persisted while the above therapy was given. During this period he also developed left lower lobe pneumonia and left sided pleural effusion.

On November 23, 1971 the above therapy was discontinued and clindamycin (600 mg IV q 6 hours) was started. No other antibiotics were given. The patient became afebrile in 48 hours.

Blood, wound, urine, and sputum cultures were done twice weekly while he was receiving clindamycin. Several blood cultures were negative. The wound culture yielded only *Pseudomonas aeruginosa* but no anaerobes. The sputum and urine yielded no pathogens.

In this case the response was dramatic and rapid. The patient was extremely ill prior to initiating clindamycin therapy. (Bacteroides appeared to be the major pathogen.) The wound healed in spite of the presence of contaminating organisms. The pleural effusion disappeared and the lung cleared over a one week period. The patient was discharged in two weeks after the initiation of IV clindamycin therapy. He was readmitted later for colostomy repair.

Case History II.

C. H., a 24 year old male, was shot in the abdomen 5 years ago. At this time he underwent exploratory laparotomy with a colostomy. The patient had a stormy febrile postoperative course from which he gradually recovered. The colostomy was later closed and he was asymptomatic for 5 years. At the time of the present admission the patient noted the sudden onset of fever and chills and inability to walk. He was admitted with the diagnosis of appendicitis. A laparotomy was done and the appendix was found to be normal. On further exploration a large retroperitoneal abscess was discovered and 250 cc of foul smelling pus was drained. The culture done in the routine laboratory was reported as sterile but when cultured with modern anaerobic techniques, the following anaerobic bacteria were isolated: (1) *Peptostreptococcus sps.;* (2) *Clostridium sporogenes;* (3) *Bacteroides fragilis;* and (4) *Eubacterium lentum.*

The patient was initially treated with cephalothin and later changed to Penicillin but the drainage persisted. He also continued to be febrile until IV clindamycin therapy was ini-

(Continued on page 72)

TABLE III

Anaerobic Bacteria Isolated from Abdominal Wounds in 55 Patients Admitted with Small and Large Bowel Injuries to the Trauma Unit of the Cook County Hospital

Morphology	Number of Isolates
I. Cocci	
A. Gram-positive	
1. Peptostreptococcus	12
2. Peptococcus	11
B. Gram negative	
veillonella	1
II. Rods	
A. Sporeformers: Clostridia	
1. Cl. difficile	1
2. Cl. ghoni	1
3. Cl. sphenoides	2
4. Cl. sordellii	1
5. Cl. species (unidentified)	8
B. Non-spore forming rods	
1. *Gram-positive*	
a. Proprionibacterium acnes	3
b. Eubacterium	
E. biforme	2
E. ventriosum	1
E. filamentosum	1
2. *Gram-negative*	
a. Fusobacterium	2
b. Bacteroides	
B. fragilis	16
B. trichoides	1
B. melaninogenicus	1

Ano-Rectal Crisis

By Crile Doscher, M.D., F.A.C.S.

"ANO-RECTAL CRISIS" is common in the practice of colon-rectal surgery, and it must be dealt with tactfully, yet professionally in order to render a beneficial, hopefully curable, service to the patient.

"Ano-Rectal Crisis" follows a very definite and usually consistent system complex:

1. *Itching and Burning* of the peri-anal area.

2. *Pain* in the rectal area (proctalgia), which is usually one sided, and occurs frequently on the side opposite the patient's handedness—i.e., left-sided rectal pain in the right-handed person, and visa versa.

3. A feeling that the *anus is too tight.*

4. A *crawley sensation* at the anal verge, like a feeling of worms.

5. *Peri-anal secretion* which is foul-smelling, stains the clothes, and is often described as a leakage of the bowel contents.

These five symptoms are practically pathognpneumonic for *ano-rectal crisis* and the diagnosis can be suspected immediately while taking the patient's history. The patient may often present an entire symptom complex or a combination of one or more together. The patient often comes to his physician complaining of hemorrhoids, while indeed he describes the symptoms above. There, of course, is no relationship to hemorrhoidal disease, although they may indeed appear simultaneously. The differential diagnosis is made by history and complete proctologic examination.

Characteristically, persons with ano-rectal crisis are of a particular personality type. The vast majority will freely admit that they suffer from chronic anxiety/tension. They are basically compulsive types with perfectionistic personalities. They are totally involved with their jobs, highly competitive, fastidious and very conscientious people. The sex ratio appears to be about equal.

It is interesting to note that these functional syndromes almost invariably occur in isolated organ systems. Rarely are two systems ever involved simultaneously. This is to say, patients displaying ano-rectal crisis don't usually complain of tension headache, or irritable bladder, and visa versa. It is, however, common to note the presence of an irritable colon in association with ano-rectal crisis. Rectal bleeding, mucosal prolapse and a definite change in bowel habit are conspicuously absent in the history of patients with ano-rectal crisis. Differential diagnosis of these conditions is usually no problem. The history is invariably the give-away.

However, completeness is to be stressed, for it is most important not to overlook more significant and possibly concomitant and coinciden-

CRILE DOSCHER, M.D., F.A.C.S., is a surgeon with special training in vascular surgery and colon and rectal surgery. He received his M.D. at New York City Medical College and served a post graduate rotating internship at the Cleveland Clinic, Cleveland, Ohio.



tal problems. Colorectal diagnoses such as fissures, fistula en ano, peri-anal dermatitis, ulcerative colitis of either the mucosal or transneural variety, polyps and neoplasms are easily excluded by conscientious examination. Complete proctology should include digital examination, anoscopy, proctosigmoidoscopy and a Barium study of the colon.

In the case of ano-rectal crisis, with or without an irritable colon component, the above examination is generally normal. The anatomical architecture and structure of the rectum on rectal inspection usually are normal. Patients, however, with coexisting irritable colon syndromes often will manifest undue discomfort on proctoscopy and the scope is difficult to pass beyond the 15 cm mark. Barium enema very frequently displays marked spasticity and even "thumb printing" of the left colon.

Treatment of ano-rectal crisis is generally symptomatic. A brief discussion of the cause and effect relative to the patient's anxiety/tension state is essential. It is also essential that patients be informed that this syndrome bears no relation to hemorrhoids or other ano-rectal conditions. They must be reassured that there is no structural abnormality present. We often explain to the patient that his or her target organ for anxiety tension is the rectum and it is quite similar to having a tension headache, only occurring in the rectum. Many patients do very well with just reassurance. Most, however, do better with a regimen including Bentyl 20 mgm q.i.d., and Kondremul 1 oz. q.h.s.

On occasion the addition of Belladonna and Opium suppositories, grains ½, is very helpful, and is prescribed on an "as necessary" basis, for the more intractible cases. No dietary restrictions need be employed. On this regimen our control rate nears 100%. Hemorrhoidectomy, either by surgery or by elastic ligation, should *not* be considered. It is not only inadvisable but will produce a very ungrateful patient when all is said and done and the annoying symptoms persist—sometimes worse. When irritable colon syndrome occurs simultaneously the same treatment is followed and satisfactory control is obtained.

The syndrome of *Ano-Rectal Crisis* is little mentioned in the literature, yet it is commonplace in the office practice of colon-rectal surgery. A grateful patient results from the proper approach to this problem. ◄

Methadone in industry

I think there is a tremendous danger that an agency dispensing a drug like methadone might succumb to the temptation of controlling human behavior by the implicit right to be able to grant or withhold the powerful drug. I would find this objectionable ethically because I feel no agency should wield this power over an individual, especially when it involves medical treatment. Psychologically we can readily understand how many addicts could only see this as a maneuver which coercively exploits his addiction to force him to conform and surrender to a society with which he is already at war. Work in this setting could well be seen as slavery, with the whip being a drug which could be withheld or granted, depending on compliance.

Industry is in a particularly powerful position to steer clear of this dilemma. If, among its other medical services, an industry offered a methadone program and perhaps a referral service to a Synanon group, it would be coercing no one. Of course, the argument could be raised that the personnel manager might wind up with the whip, but I believe industrial physicians have been over this battle before and are well aware of the dangers involved. (Henry P. Coppolillo.: The Age of Aquarius (Youth and Drugs) **Jl. Occupational Medicine** 14:5 (May) 1972, pgs. 373-376.)

By Joseph C. Cleveland, M.D., and William M. McCormack, M.D./Danville

REPORT OF A CASE

Kinked internal carotid artery: Observation on etiology

WIDESPREAD use of angiographic techniques has demonstrated a large number of patients with kinked internal carotid arteries. Gass[1] correlated kinking with cerebral insufficiency in 1958. We wish to report a patient with a kinked internal carotid artery, traceable to an early age, but becoming symptomatic in the fourth decade of life.

Case Report:

A 49-year-old white, male farmer was admitted to the hospital for evaluation of a pulsating tumor in the right side of his neck. The mass had been noted in the patient's early childhood, but was asymptomatic. Prior to entry into the hospital, the patient noted a noise in the right ear, and became irritable because of an unusual sensation in the right side of his head. He stated his blood was not flowing properly, but that "it's like the blood is going up and around something." He correlated the disturbance with the tumor. No neurologic disturbance was present.

He was admitted to the hospital on November 29, 1970. A percutaneous carotid arteriogram was attempted, but was unsuccessful. On December 2, 1970, he was taken to the operating room, and an open arteriogram was performed (Fig. 1). The kink was surrounded by dense fibrous bands adherent to the prevertebral fascia. The lesion was corrected by anastomosis after resection of the excessive length of the internal and common carotid arteries. The external carotid artery was ligated and divided (Fig. 2). A shunt was not used. The patient recovered from surgery uneventfully and left the hospital on December 8, 1970. He was completely relieved of his symptoms and remains well to the time of this report.

Comment

Symptomatology resulting from kinking of the internal carotid artery is now a well recognized syndrome.[1,2] Symptoms are usually related to cerebral insufficiency but may be related to the mass in the neck.

The age range of symptomatic patients with this entity approximates the age range of patients

with arteriosclerotic occlusive lesions. Thus, the etiology has frequently been assumed to be atherosclerotic, with loss of elasticity plus elongation of the carotid vessels producing the kink. However, several authors have observed a kink in very young patients (Julian in a 5 year old, Suzuki in a 15 month old child, and Parish in five children aged 4 to 12 years).[2,3,4]

In 1924, Cairney, in his dissection of fetuses, demonstrated tortuosity of the cervical segment of the internal carotid artery, both unilaterally and bilaterally.[5] He commented that the tortuosity seen in this vessel is not necessarily a result of senescence.

Weibel and Fields found significant tortuosity in angiograms in three patients under age 10 and in five patients between ages 11 and 20.[6] In their excellent review of 2,453 angiograms performed on 1,407 patients from 6 weeks to 81 years of age, they point out the anatomic and pathologic differences between tortuosity, coiling and kinking of the carotid arteries.

Spence reported a dense fibrous band of connective tissue associated with absence of the external carotid artery and obstructive kinking of the internal carotid artery.[7] Our patient also demonstrated dense connective tissue around the kink with attachment to the prevetebral fascia. However, the external carotid artery was present.

That significant kinking diminished blood flow has been experimentally verified by Derrick, et al.[8] As expected, the more severe the kink, the less the blood pressure and flow distal to the kink.

Treatment may consist of either resection of redundant artery or re-implantation of the internal carotid artery lower on the common carotid.[2,9] In children, simple repositioning of the artery has been done.[2] We chose the resection and reanastomosis technique because it seemed more "anatomic" in this patient.

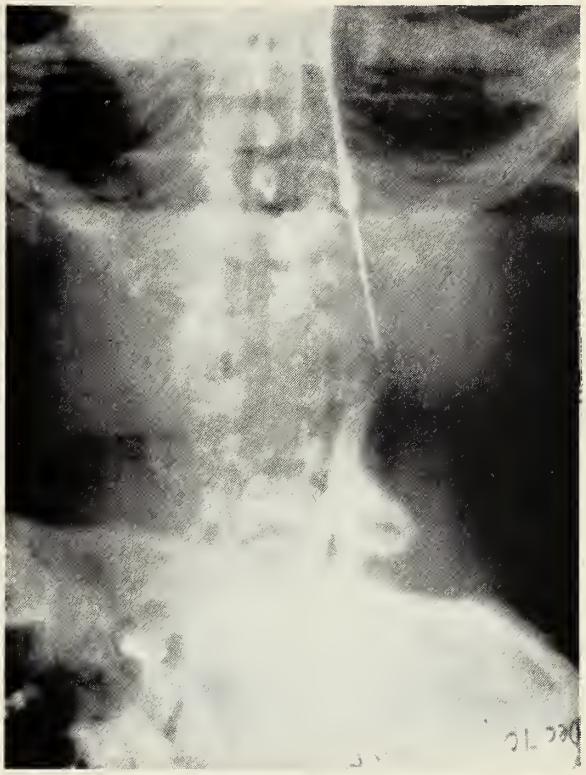


Figure 1. Operative arteriogram showing severe kink in right internal carotid artery.

On the basis of this patient's findings, plus a review of the pertinent literature, we believe that extracranial kinking of the internal carotid artery associated with connective tissue bands may be a distinct clinical entity. It apparently occurs as a congenital anomaly or variant, although it may not become symptomatic until superimposed atherosclerotic changes are manifest.



JOSEPH C. CLEVELAND, M.D., is in private practice; general, thoracic and peripheral vascular surgery in Danville. He received his M.D. from Western Reserve University of Medicine and served his internship and residency in surgery at Western Reserve University Hospital of Cleveland.



WILLIAM M. McCORMACK, M.D., is director of the Department of Radiology, Lake View Memorial Hospital, Donville. He received his M.D. from the University of Louisville. Internship was taken at the University of Texas Medical School ond o three year residency in radiology wos taken ot the University of Louisville.

Kinked Carotid Artery

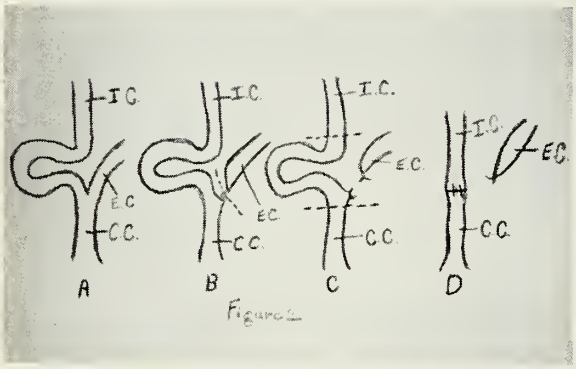


Figure 2. Surgical repoir of the kinked right internol carotid artery is illustrated. (C.C.=common corotid; E.C.=external carotid; .IC.=internol corotid.) A=lesion prior to repoir. B=ligation ond division of externol corotid artery. C=resection of excessive length of common ond internol corotid arteries. D=Anastomosis of internal ond common corotid orteries (repoir completed).

Summary

A patient is presented with evidence of a congenital abnormality of his right internal carotid artery. Significant symptoms associated with kinking occurred when the patient was 49 years of age. ◄

References

1. Gass, H. H.: Kinks and Coils of Cervical Carotid Artery. *Surg. Forum* 9:721, 1958.
2. Julian, O. C. and Javid, H.: Surgical Management of Cerebral Arterial Insufficiency. *Curr. Probs. In Surg.*, March, 1971, p. 33.
3. Suzuki, J., O'Hara, I., and Saso, S.: Improvement of Convulsion by Operation for Kinked Internal Carotid Artery in an Infant. *Tohoku. J. Exp. Med.* 84:137, 1964.
4. Parrish, C. M. and Byrne, Jr., J. B. Society of Vascular Surgery, 1971 meeting, reported in *Medical World News* 12:32, July 9, 1971.
5. Cairney, J.: Tortuosity of the Cervical Segment of the Internal Carotid Artery. *J. Anat. (London)* 59:87, 1924.
6. Weibel, J. and Fields, W.: Tortuosity, Coiling, and Kinking of the Internal Carotid Artery. *Neurology* 15:7, 1965.
7. Spence, W. T.: Pseudo-stroke. *JAMA* 186:76, 1963.
8. Derrick, J., Estess, M. and Williams, D.: Circulatory Dynamics in Kinking of the Carotid Artery. *Surgery* 58:381, 1965.
9. Quattlebaum, J. K., Upson, E. T., and Neville, R. L.: Stroke Associated with Elongation and Kinking of Internal Carotid. *Ann. Surg.* 150:824, 1959.

Twenty Three Clinics for Crippled Children

Twenty three clinics for Illinois' physically handicapped children have been scheduled for August by the University of Illinois, Division of Services for Crippled Children. The Division will conduct sixteen general clinics providing diagnostic orthopedic, pediatric, speech and hearing examination along with medical social, and nursing services. There will be five special clinics for children with cardiac conditions, and two for children with cerebral palsy. Any private physician may refer to or bring to a convenient clinic any child or children for whom he may want examination or consultative services.

August—

2 Springfield Pediatric Neurological-Diocesan Center
2 Hinsdale—Hinsdale Sanitarium
2 Carlinville—Carlinville Area Hospital
3 Sterling—Sterling Community Hospital
3 Lake County Cardiac—Victory Memorial Hospital
8 Peoria—St. Francis Hospital
8 E. St. Louis—Christian Welfare Hospital
9 Champaign-Urbana—McKinley Hospital
10 Springfield—St. John's Hospital
11 Chicago Heights Cardiac—St. James Hospital
15 Rock Island Area General—Moline Public Hospital
16 Chicago Heights General-St. James Hospital
17 Elmhurst Cardiac—Memorial Hospital of DuPage County
17 Bloomington—Mennonite Hospital
17 Rockford—Rockford Memorial Hospital
22 Peoria—St. Francis Hospital
22 Belleville—St. Elizabeth's Hospital
23 Springfield Pediatric Neurological—Diocesan Center
23 Aurora—St. Joseph Mercy Hospital
25 Evanston—St. Francis Hospital
25 Chicago Heights Cardiac—St. James Hospital
28 Peoria Cardiac—St. Francis Hospital
29 E. St. Louis—Christian Welfare Hospital



new pharmaceutical specialties

by paul dehaen

For detailed information regarding indications, dosage, contraindications and adverse reactions refer to the manufacturer's package insert or brochure.

Single Chemicals: Drugs not previously known, including new salts.

Duplicate Single Products: Drugs marketed by more than one manufacturer.

Combination Products: Drugs consisting of two or more active ingredients.

New Dosage Forms: Of a previously introduced product.

The following new drugs have been marketed:

DUPLICATE SINGLE PRODUCTS

ERYPAR: Antibiotics—B&M Spectrum ℞
Manufacturer: Parke-Davis
Nonproprietary Name: Erythromycin stearate
Indications: Infections due to susceptible organisms.
Contraindications: Hypersensitivity
Warnings: Safety for use during pregnancy has not been established.
Precautions: Pts with impaired liver function.
Dosage: Adults: 250 mg every 6 hrs. Children: 30-50 mg/kg/day in divided doses.
Supplied: Tablet, 250 mg

KESSO-PEN-VK: Penicillin ℞
Manufacturer: McKesson
Nonproprietary Name: Penicillin, phenoxymethyl potassium
Indications: Mild-moderate infections due to susceptible organisms.
Contraindications: Hypersensitivity
Warnings: Serious hypersensitivity reactions can occur.
Precautions: Allergic history
Dosage: Varies according to type and severity of infection.
Supplied: Tablet, 250 mg and 500 mg

COMBINATION PRODUCTS

EFO-TUSSIN Antitussive o.t.c.
Manufacturer: Fougera
Composition: Each 5 cc contains:

Dextromethorphan Hydrobromide	10	mg
Ammonium chloride	50	mg
Phenylpropanolamine HCl	8.3	mg
Chlorpheniramine maleate	1.25	mg
Sodium citrate	120	mg
Alcohol (by volume)	5%	

Indication: Temporary relief of coughs due to the common cold.
Dosage: As required
Supplied: Bottles

NATALINS FA Prenatal Vitamin ℞
Manufacturer: Mead Johnson
Composition: Each tablet contains:

Vitamin A	6000	units
Vitamin D	400	units
Vitamin E	10	units
Vitamin C	100	mg
Vitamin B1	1.5	mg
Vitamin B2	2.0	mg
Vitamin B6	2.5	mg
Vitamin B12	6	mg
Niacin	20	mg
Folic Acid	1	mg
Pantothenic Acid	10	mg
Calcium	250	mg
Iron	40	mg

Indication: Prenatal vitamin-mineral supplement
Dosage: One tablet daily
Supplied: Tablets

NEW DOSAGE FORM

KESSO-PEN-VK Penicillin ℞
Manufacturer: McKesson
Nonproprietary Name: Penicillin, phenoxymethyl potassium
Indications: Mild-moderate infections due to susceptible organisms.
Contraindications: Hypersensitivity
Warnings: Serious hypersensitivity reactions can occur.
Precautions: Allergic history
Dosage: Varies according to type and severity of infection.
Supplied: Solution, 125 mg and 250 mg per 5 cc

Maternal Death Study 5

(Continued from page 42)

the early tearing and hematoma of the cervix. It was felt that perhaps this bleeding was occurring from a torn vessel in the cervix.

There was no mention of inspection of the birth canal nor of the cervix nor of the uterine cavity (expect that incidental to massage of the uterus) in an effort to determine any source of bleeding other than uterine atony. Atony is known to occur following rapid labors and labors induced with oxytocics particularly in the multiparous individual, whose second and third stage are not very carefully managed. Many authorities recommend a slow deliberate emptying of the uterus taking 3-5 minutes, and the continuous administration, following the delivery of the baby, of an oxytocin containing solution in an attempt to maintain good uterine tone. Large doses of oxytocins, in the neighborhood of 40-50 units, may be necessary in order to overcome uterine atony.

The most tragic aspect of this case was, however, that over two hours were allowed to elapse before the severity of the situation was appreciated during which time no effort was made to transfuse the patient nor to execute definitive measures for the control of the bleeding. Your committee makes no definite recommendation relative to the use of the pack, but it is obvious that if the pack is firmly placed and still is not effective, other measures must be added. Hemorrhage continues to be the number one cause of death in Illinois, and the only way in which it can be effectively combated is by having in one's mind a definite outline of treatment. First of all, a vein should be opened and blood be made available. Secondly, the source of the bleeding must be located following a systematic approach; most people feeling that one starts with the uterine body, making sure it is contracted and free of tears, then proceeds to the cervix, then to the vagina, and then to the vulva as sources of hemorrhage. Good anesthesia, good exposure, and adequate assistance are essential as are availability of plasma expanders and whole blood. Many obstetricians now recommend as a routine procedure that fluids be started when the patient is admitted to the delivery room, thus providing ready access for intravenous medication. Delay in establishing definitive treatment can only result in tragedy. ◄

the view box

(Continued from page 43)

DIAGNOSIS: This case is being presented against the advice of many of my colleagues who feel that at best it is a sick joke. The "aneurysm" which is seen on the lateral film is in effect an amputation of this patient's left humerus at the mid-shaft with an overhanging soft tissue stump. It has been called by some of our best observers an aneurysm or a carcinoma of the lung. The PA film should arouse suspicion because of the absence of anything resembling an aneurysm in the region of the ascending aorta or sinus of valsalva. In addition the increase radiolucency of the left upper lung field is the result of failure of usage of the left upper extremity muscles.

ekg of the month

(Continued from page 49)

Answers:

A) 2,4 There are Q waves in V_{1-3} (anteroseptal), with persistent elevation of the ST segments in these leads. Such ST elevation after infarction frequently is associated with ventricular aneurysm.

B) 1,2,3 Ventricular aneurysms are frequently filled with thrombus. This patient's transient hemiplagia suggests cerebral embolism. Anticoagulation may help to prevent further embolic episodes. Surgery is not required for all ventricular aneurysms, but only for those complicated by congestive heart failure, embolic problems, and perhaps for persistent arrhythmias and angina. The left anterior descending coronary artery supplies the anterior wall of the left ventricle and the anterior two-thirds of the ventricular septum.

Cancer Research Receives Renewed Financial Aid

Financial and technical support for the research of Barnett Rosenberg, M.D., into the use of platinum compounds as chemotherapeutic agents for the treatment of certain types of cancer has been renewed by the Engelhard Industries Div., Englehardt Minerals & Chemicals Corp.

investment corner

Too many doctors take the wrong Rx

Jack P. Higgins, vice president
Capital Resources Corp.
Financial Advisers, Inc.
307 North Michigan Ave.
Chicago, Illinois 60601
(312) 236-4468

The story that what doctors talk about at medical conventions is stocks may be exaggerated. But the fact that the joke exists is evidence that stocks occupy a disproportionate share of doctors' attention.

It is fun to take risks on the market if you can afford it, but the game can be expensive. No doctor should have all his eggs in the equity basket. Even if uniformly successful, a portfolio of common stocks occupies too much of the doctor's everyday attention.

More importantly, it does little to help the doctor with tax problems that result from high, unpredictable, uneven income that cannot be deferred over a long time span.

Real estate is one of the growing popular tax-shelter investments. The shelter derives mainly from interest on the mortgage and from depreciation of the building improvements. Depreciation is based on the assumption that a building will decrease in value over the years. Actually, in recent years the case has been exactly the opposite.

The full value of a commercial property may be depreciated by the investor even though he has contributed but a part of the original cost. Depreciation is a paper loss, not money paid out. Thus there is no offsetting of the amount of income brought by rents.

Equipment-leasing also provides tax deferral through depreciation and interest deductions. In these arrangements the investors buy the equipment, financing up to 80% of it. The rental income pays the financing charges and produces a cash flow after expenses. Depreciation and finance charges may be accelerated to permit the investor to recover his cash outlay in three years. Beyond that time (three years) cash flow is taxable at personal rates so that an equipment-leasing arrangement is perhaps of maximum advantage to a doctor whose retirement is three to four years away.

Oil and gas exploration can produce very high rewards, but there are many more dry holes than producing ones. The risk is great. Drilling costs up to 70% of the cost of a productive well are fully deductible. The depletion allowance on a producing well (22% of gross) may be excluded from reportable income.

Cattle feeding contracts produce tax-shelter because estimated feed costs may be prepaid in a high income year and sales income from the animals derived in the next. Cattle breeding has an additional tax advantage in that sales of heifers retained for more than 24 months may be reported at the capital gains rate.

There are other forms of tax-shelter—one or

(Continued on page 76)



practice management

Unemployment Compensation And The Solo Doctor

James N. Anstett, Consultant
Professional Business Management, Inc.
67 East Madison St., Chicago, Illinois 60603

(312) 782-2282

If you have any office employees, you are probably subject to the amended State Unemployment Compensation Act that went into effect at the beginning of this year.

This amendment to the State's Unemployment Compensation Act has prompted many physicians to call upon specialists in the management consulting and accounting fields in order to find out how this change in the law applies to their practice. Those clients who have never before been subject to the law have asked a myriad of questions such as "Why?" "What is it for?" "Who is covered?" "Where does the money come from?," etc. To clarify any uncertainties, we will attempt to answer these and other questions concerning the Unemployment Compensation Act and how it pertains to the physician.

The purpose of the law is stated in its introduction. The act declares that involuntary unemployment is of general concern to the people of the state because of its serious threat to their health, safety, morale and welfare. Thus, the general assembly set up a system to provide payments to those involuntarily unemployed to lessen this problem.

Prior to January 1, 1972, only those employers who had four or more employees for twenty weeks of the calendar year were liable under the provisions of the law. Covered in the new amendment, however, are those who either pay or paid $1500 in wages for a calendar quarter, or who have or had one employee for any part of a day for twenty weeks of the year. These wage and employee requirements apply to either the prior or current year. Put more simply, any doctor who has an office employee is required to pay the Unemployment Compensation tax. There are, however, exceptions to this general rule. Any person who is employed by a son, daughter or spouse, or a child under twenty-one employed by his father or mother, is not considered an "employee" and no contribution is to be made for that individual. For example, if a solo practitioner has his wife as his only employee, he is not liable under the law.

(Continued on page 72)



editorials

Thieving in Libraries

Many years ago I drove from Taxco to Mexico City with Juan O'Gorham, the famous Mexican architect. As we approached the university, we discussed the beautiful mosaic work on the large windowless library. "Who was the architect?" I asked. He pointed to himself, and explained why there were no windows in the building. The old library lost too many books because the students tossed them out of the windows into the arms of their friends. Book losses from the new library were negligible.

The September 1971 issue of *Annals of Internal Medicine* contained an editorial "Thievery in Medical-School Libraries."[1] It was initiated by the librarian of a Philadelphia medical school when he announced to the faculty that replacement costs for "missing" books and journals would be an estimated $7,500 to $10,000, or 10% of the annual acquisitions budget. Questionnaires were sent to half of the medical school libraries in the United States. In response, 40% of 36 respondents reported that they had major losses.

The editorial also provoked many letters[2] to the editor. "I can assure you that you speak not only for medical school libraries but also for medical libraries in hospitals not affiliated with medical schools." This was written by the staff librarian of a Phoenix (Ariz.) hospital where losses were at least 10%. ". . . the fact remains that men and women who wouldn't stoop to defrauding the newspaper dispensing machine of a dime have no qualms about filching a $25 book from the medical library."

Another letter went as follows: "Our medical-nursing collection suffers from the same ailment." And in England, they have the same problem —perhaps worse. "Theft and vandalism in medical schools is by no means confined to St. Thomas (London). The bar at Bart's has been closed for repairs and, like our own Amalga-

mated Clubs, they 'mislaid' a television set. St. Mary's billiard table at Wilson House was slashed in several places, according to the Gazette."

In 1962, theft was one of the reasons librarians at the National Library of Medicine were so happy to move into new quarters. The old building had too many back doors. The new building has better security measures. In some areas, book theft has been cut by installing detection devices, or checking users at points of entry and departure.

As an aside, books are high on the list of items stolen by male shoplifters. This is not true of women shoplifters. My friend, Carl Kroch of Kroch's & Brentano's, recently received a letter from a young man leaving Chicago. "I have just finished college, and wanted you to know that I have a sizeable library; all the books were stolen from your stores. Many thanks."

Obviously, the "bad apples" in the medical profession probably were bad long before they were graduated and entered the practice of medicine. Perhaps O'Gorham was ahead of his time. Always remember, when designing a library, no windows, and just a front and back door. ◄

T. R. Van Dellen, M.D.
Editor

References

1. Thievery in Medical-School Libraries. *Annals of Internal Medicine* (Sept.) 1971, 75:3, pgs. 469-470.
2. Letters, Comments, and Corrections. *Annals of Internal Medicine* (Dec.) 1971 75:6 p. 968.

(See Guest Editorial—page 85)

Obituaries

***Adler, R. F.,** Chicago, died May 26, at the age of 60. He was a past president of the medical staff of South Chicago Community Hospital. Dr. Adler has been on the South Chicago staff since 1948.

***Berkwits, Edward,** Chicago, died January 6, at the age of 45. He attended the Chicago Medical School.

***Bica, Gaetano A.,** Chicago, died May 21, at the age of 65. He recently retired as a medical officer and maintained an office in Chicago.

Bloom, William, Oak Lawn, died May 11, at the age of 72. Dr. Bloom was a retired professor of anatomy at the Pritzker School of Medicine, University of Chicago. He was the co-author of a textbook on histology widely used by medical students.

***Bohning, Anne L.,** Chicago, died May 14, at the age of 80. She was on the staffs of Michael Reese and Presbyterian-St. Luke's Hospitals for many years. A graduate of the University of Chicago and Rush Medical School, she also served on the staff of the La Rabida Sanitarium.

****Brodsky, Jacob,** Chicago, died at the age of 80. He was a staff physician at Northwestern Hospital and he practiced medicine for more than 50 years.

***Brown, Garland Greene,** Chicago, died December 29, at the age of 72. He was affiliated with Bethany Methodist Hospital.

***Dreikurs, Rudolf,** died May 28, at the age of 75. Internationally known psychiatrist and author of 170 books and articles on psychology. He founded the Alfred Adler Institute and the Community Child Guidance Centers now known as the Family Education Association. He was on the faculty of the Chicago Medical School for more than 25 years.

****Garrison, Lester E.,** Chicago, died May 16, at the age of 74. He retired 18 years ago as a physician and a surgeon with offices in Chicago. He was on the staff of Wesley Memorial Hospital and practiced medicine for more than 50 years.

Hovde, Carl H. R., Normal, died October 12, 1971, at the age of 87.

Humphreys, Eleanor Mary, Chicago, died December 28, 1971, at the age of 79. He was on the faculty of the University of Chicago School of Medicine.

***McCarty, Franklin B.,** Chicago, died May 6, at the age of 83. He was chairman of the department of surgery at St. Joseph's Hospital. He was one of the founders of the American Board of Surgery, and the author of many articles on abdominal surgical procedures. He had been a physician for more than 50 years.

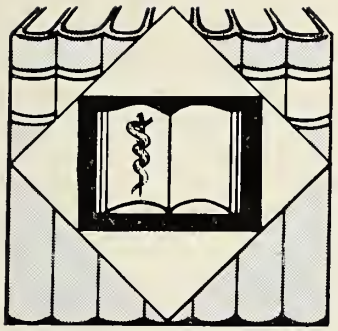
Meyer, Charles, Western Springs, died May 29, at the age of 61. He was on the staffs of Cook County and Columbus Hospitals for 34 years.

Tingler, Adelaide. Berwyn, died May 27.

Turban, A. A., Chicago, died May 25.

***Walton, Joseph E.,** Homer, died April 28, at the age of 61. He graduated from the University of Illinois and UI Medical School.

**Denotes member of ISMS*
***Denotes member of 50-Year Club and ISMS*



the doctors library

Handbook of Legal Medicine. Published June, 1970, 3rd Edition. By Alan R. Horitz, M.D. and R. Crawford Morris, LL.B. 230 pages, C. V. Mosby, St. Louis. $8.75.

An updated, formalized discussion of this phase of medical practice is long overdue.

This third edition would seem to fulfill the updating requirement. The authors express the feeling that the brief format is all that is required by the average medical practitioner. And here too, this small volume achieves the goal of the authors.

However, a volume such as this should be more comprehensive. There is a paucity of material published for teaching purposes, both for the medical student and house staff.

The authors seem to possess the expertise necessary for a more comprehensive discussion and this handbook could serve as a foundation.

The handbook fulfills the authors' desire, but could become the foundation for a needed text.

Vincent Sarley, M.D.

Management of High-Risk Pregnancy and Intensive Care of the Neonate. 2nd Edition. By S. Gorham Babson and Ralph C. Benson. Published in 1971 by C. V. Mosby Company, St. Louis.

This second edition of this book has been expanded to include all neonates and not just premature infants. It considers the responsibilities of all members of the health care team. It is well-written and easily understood. The authors' method of expression is deliberate, and portions of the book are in outline form for greater clarity. The tables and charts are clear and uncluttered. References at the back of each chapter and section are profuse and current. The definitions in the appendix help to clarify the profusion of terms which has evolved with the development of neonatology.

The first half of the book deals with the fetus and emphasizes the attitude that the fetus should receive greater priority in obstetric management. The complications of pregnancy are referred to as they affect the fetus. The high-risk factors in women are delineated, and the incidence of associated perinatal mortality and morbidity with each are illustrated.

There is a good section on the effects of maternal drugs. The causes of early delivery are outlined and its prevention discussed. The indications for early delivery are presented along with a discussion of the maternal disease entities involved, their symptoms, laboratory findings, differential diagnosis, and treatment. The antenatal growth is described, and methods of its assessment are brought forth and discussed thoroughly along with proper antenatal care, emphasizing maternal diet and emotional stress.

Fetal distress is covered well, and labor and delivery are presented with special considerations given to eliminate errors of omission as well as errors of commission.

The second half of the book deals with the neonate. Resuscitation of the newborn and the necessary equipment in the delivery room are covered with good illustrations. The infants are classified by weight and gestational age with comprehensive graphs included. Intensive care of the neonate is detailed with a section on nursing care. Postnatal problems are divided into physiologic systems with incidence, pathogenesis, clinical features, diagnostic procedures, and treatment in outline form. A separate chapter is devoted to discharge of the neonate from the hospital with the responsibilities of those concerned and instructions for the mother. The authors emphasize that follow-up care is important and delineate the sequelae of prematurity.

This book is an important one for pediatricians and obstetricians as well as for the family physicians, nurses, and paramedical personnel who have equally frequent contact with the pregnant woman and neonate.

Paul D. Urnes, M.D.

House Amends Bylaws

Two major changes in the bylaws of the Illinois State Medical Society were voted by the 1972 House of Delegates. The first of these amendments clarifies the classes of society membership and provides for medical students to join ISMS for the first time.

The other major change involves the business of the society, which is conducted through a system of councils and committees that make recommendations for actions by the Board of Trustees and for establishment of policy by the House of Delegates.

Like many other organizations, the Illinois State Medical Society has created committees and developed activities over the years—adding more from time to time and rarely eliminating any. About five years ago, in a move to simplify what had grown into an unwieldy structure, all existing committees were assigned to one or another of eight councils. This action served to channel committee reports to the Board of Trustees into eight pipelines rather than having 50 or more committees reporting individually. But administratively, it was really nothing more than a group of councils superimposed on a lot of miscellaneous committees, some of which had been entrenched in society affairs for a generation.

As important as this step was in streamlining the business of the society, there was little effort made to give the councils any real power over old-time committee chairmen nor much of an incentive to evaluate the functions and purposes of all these committees.

Under the revised bylaws, these councils become standing committees of ISMS: Medical-Legal, Governmental Affairs, Education and Manpower, Economics and Peer Review, Environmental and Community Health, Public Relations and Membership Services, Mental Health and Addiction, and Social and Medical Services. The bylaws list the areas of concern for each. Subcommittees may be set up under each council on an ad hoc basis; they may be used only for the purpose for which they were set up and are to be disbanded when that purpose is accomplished.

Councils may form such subcommittees as they need within their own membership. Appointment of other subcommittees requiring additional personnel or members with special knowledge or expertise may be requested through the Board of Trustees. By expanding the councils and providing for subcommittees, it is hoped that the total number of physicians involved in society business will remain about what it has been.

In addition to the councils and their ad hoc subcommittees, the bylaws also provide for the committees necessary to operate the House of Delegates, several committees within the Board of Trustees, and an Ethical Relations Committee.

Since the amended bylaws were adopted in March, the Board has created several free-standing committees whose responsibilities are such a specialized nature that it would be impractical to have them report to a council. These are Liaison with Blue Cross and Blue Shield, Hospital Manpower, Insurance, Drugs and Therapeutics, Joint Convention Management, Special Project for the Illinois Department of Mental Health, and Certification of Need (in connection with H.B. 2653).

ISMS Responsive To Counties

(Continued from page 8)

illicit drug dealers rather than additional regulation of legitimate professionals.

While we physicians should be willing to help curb drug abuse in Illinois through any *reasonable* means, those means should be pragmatic—not bureaucratic and academic.

As I said, the hearing was April 12 . . . and the hearing officer filed his report May 5. But as of June 10 the department's recommendations had not been released. . . . Bureaucratic machinations seem to be interfering with good government—government responsive to the best interests of the public.

We have made our point!

In this instance ISMS took immediate and forceful action to try to answer the needs of a county medical society.

In the months to come, I will do everything in my power to do even more to strengthen the ties between our state and county medical societies.



what goes on

a guide to continuing education

July 16-20—American Association for Clinical Immunology and Allergy

Annual Meeting

This meeting will include a post-graduate course to prepare physicians to take the forthcoming certification examination to be given by the new Conjoint Board in Allergy.
Contact: Richard Jackson, M.D., 444 Hermann Professional Bldg., 6410 Fanin, Houston, TX 77025

Washington Plaza Hotel, Seattle

July 17-21—Division of Design and Construction

AHA Institute Simulates Hospital Planning

This institute was organized to prepare hospital decision makers for the problems they will face in planning and designing new institutions. It will attempt to help them by teaming medical staff members, architects, hospital administrators, board members, engineers and consultants in four days of intensive, simulated hospital planning.
Contact: Mrs. Ruth Blaine (312) 645-8220

AHA headquarters, Chicago, Illinois

July 17-28—University of Wyoming

Nutrition Education Workshop

Contact: Dr. Martha A. Poolton, Division of Home Economics, University of Wyoming, Laramie, WY 82070

University of Wyoming, Laramie

July 21-22—American Association of Medical Clinics

Group Practice Meetings—Annual Sessions

This two day session will include panel discussions on computers in medicine, physicians' assistants and clinics and medical education. All interested physicians, clinic administrators and observers are invited. The meeting will be hosted by Carle Clinics Association.
Contact: John W. Pollard, M.D., Carle Clinic Association, 602 W. University Avenue, Urbana, IL 61901

Holiday Inn, Urbana, Illinois

July 27-28—Northwestern University Medical School

"Management of Common Surgical Problems"

The Department of Surgery presents this post-graduate course. There will be many distinguished guest faculty joining members of the Northwestern University faculty in conducting the course. The program will include discussions on neck surgery, gastrointestinal bleeding, common vascular problems, trauma and pulmonary function tests in surgical patients plus many more interesting procedures.
Registration is limited to 100, and is $100.
Contact: Jacob R. Suker, M.D., Dept. of Postgraduate Education, Northwestern University-McGaw Medical Center, 303 E. Chicago Avenue, Chicago, IL 60611.

Passavant Memorial Hospital, Chicago, IL

July 29-30—American Society of Anesthesiologists

ASA Workshop on Fluid and Transfusion Therapy

Registration: $50
Contact: The American Society of Anesthesiologists 515 Busse Highway, Park Ridge, Illinois 60068

Brown Palace Hotel, Denver, Colorado

July 29-August 4, August 19-August 25—University of Oklahoma Medical Center

The Drug Education Center Program

The program is designed to provide training for health related professionals and others concerned with the day to day operation of various types of drug programs, as well as those in administrative or policy-making positions. The purpose of the training is to provide current and applicable information about drugs and the complex problems associated with drug abuse and misuse.
Registration for the courses is held at the hotel at 3:00 on Sunday afternoon. Orientation pretesting and assignment to small groups follow registration.
Contact: Mrs. Helen Dunn Gouin, Director, National Drug Education Center, University of Oklahoma Medical Center, 820 Northeast Fifteenth Street, Oklahoma City, Oklahoma 73104

University of Oklahoma, Oklahoma City, OK

August 1-3—Society for Nutrition Education

1972 Annual Meeting

The 1972 SNE Annual Meeting has been developed by Dr. Philip L. White, Program Chairman, and his committee, to provide "the maximum opportunity for the interchange of information and ideas" about nutrition education. There will be ample time scheduled after each speaker or panel to allow for discussion.
Registration information may be obtained from the Society for Nutrition Education, P.O. Box 931 Berkeley, California 94701

Hotel Fort Des Moines, Des Moines, Iowa

August 2-4—Central Missouri State College

National Death Investigation Workshop

This three day workshop is designed to provide information and techniques of death investigation operations for physicians, law enforcement officials, and lawyers. Program highlights include presentations on criminal investigation at the scene, role of the medical examiner and the criminalist and physical evidence in death investigation cases.
Registration: $50
Contact: William C. Morton, Death Investigation Workshop Coordinator, TMI, Central Missouri State College, Warrensburg, MO 64093

New Science Building Auditorium, Central Missouri State College, Missouri

August 4-6—American Society of Anesthesiology

Annual Postgraduate Seminar in Anesthesiologists

Registration: $75
Contact: Elizabeth Gifford, UCLA, University Extension, 405 Hillguard Avenue, Los Angeles, California 90024

UCLA School of Medicine, Los Angeles, California

August 7-10—American Hospital Association, American Nursing Home Association, Catholic Hospital Association and the Health Industries Association

American Health Congress

This may be the largest group ever assembled to discuss health care. There will be more than 22,000 participants, 300 speakers, and 600 exhibitors. Both general and instructional sessions will be organized around the themes of "Health professionals face the challenge of providing the kind of quality care that consumers are currently demanding" and "Today health care is more than a professional matter."
Registration information may be obtained from Ann Schlinger (312) 645-9426
For general information contact: Ruth Blaine (312) 645-8220

McCormick Place, Chicago, Illinois

August 20-25—American Academy of Physical Medicine and Rehabilitation and American Congress of Rehabilitation Medicine

Academy Meeting

Sessions will include seminars on prosthetic fitting, hip reconstruction, skin problems in prosthetics and orthotics, spinal support in scoliosis and management of nonphysical disabilities in cerebral palsy. Congress sessions will include interdisciplinary forums on gait study, clinical application, and the treatment environment as a therapeutic tool.
Registration fee: Members $45, Nonmembers $60
Contact: Marvin A. Schroder, Director of Information, American Congress of Rehabilitation Medicine, 30 N. Michigan Avenue, Chicago, IL 60602

Hilton Hotel, Denver, Colorado

August 20-26—Colby College

Fourth Annual Seminar in Nuclear Medicine

This course will be concerned with the basic principles and practical aspects of nuclear medicine presented through lectures, panel discussions and illustrative cases. The material will be of value to physicians preparing for certification examination in nuclear medicine, as well as for those now devoting their full time to nuclear medicine. Basic scientists will find the course a useful orientation to the clinical uses of radioactive tracers.
Fee: $300
Contact: Paul D. Walker, Jr., Director, Special Programs, Colby College, Waterville, Maine 04901

Colby College, Waterville, Maine

August 27—American Association of Blood Banks

Emily Cooley Memorial Lecture

Dr. Bernard Pirofsky of Portland, Oregon, an authority on immunology, will deliver the 1972 Emily Cooley Memorial Lecture of the American Association of Blood Banks and receive its Emily Cooley Award. His lecture "Autoimmune Hemolytic Anemia" will be presented at a technical seminar prior to the joint Congress of the Association and International Society of Blood Transfusion at the Sheraton-Park Hotel, Washington, D.C.
Contact: AABB Central Office, 30 North Michigan Avenue, Chicago, IL 60602

Sheraton-Park Hotel, Washington, D.C.

August 28-September 1—University of Wisconsin

Postgraduate Medical Education—Emergency Care Conference

Contact: Coordinator of Post-graduate Medical Education, The Wisconsin Center, 702 Longdon Street, Madison, Wisconsin

University of Wisconsin, Madison, Wisconsin

PULSE ••• of the doctor's wife

By Mrs. Robert Hart, Pulse Editor

Auxilians Attend Congress



Mrs. Robert Hartman is President-Elect of the Woman's Auxiliary to the Illinois State Medical Society.

The American Medical Association in cooperation with other professional and allied organizations, sponsored a gigantic undertaking when the Congress on the "Quality of Life" was held in Chicago March 22-25th. Eleven hundred participants were challenged to survey, evaluate and hopefully take action to improve upon every aspect of man's existence in rural and urban living.

The opening session emphasized the emotional qualities of life to which everyone should have access—hope, fulfillment, growth, joyousness. The discussion then went on to elaborate on the desirous fulfillments of an individual. These include comfort in ones surroundings, a belief in ones self-worth, a faith in ones ability to accomplish results, ones ability to meet the challenges of daily life, a sense of freedom from dependency, and the ability to conform selectively. Other possessions discussed include many taken for granted—clean air, fresh water, parental love, and peace in the community.

Many prominent speakers and panelist were included in the program. It focused upon the various stages of life—infancy, childhood, and adolescence. A panel of high-school and college students stirred our thinking as we explored problems such as changing ethics, today's relationships between parent and teenager, the role of schools, the role of government, and the role of our present teenagers as future parents. Pleas were made for the assessment of community surveys on the needs of children. Concern was expressed for better dental care and nutritional guidance, and suggestions were made on how medical schools might assist.

The Congress expressed the view that the quality of life for a baby begins with the birth of his parents, and an analysis was made of factors influencing the health of mother and infant. Sir John Peel, physician to England's Queen Elisabeth and President of the British Medical Association, in his discussion suggested that control of problems might come about by economic and political action, and that health education must be a guide in developing responsibility toward the many problems which affect maternal health and the beginning of life.

The Honorable Carl T. Rowan, national syndicated columnist, author, and diplomat, indicated that the quality of life depends upon the political scene. He recommended as three priorities that: (1) family and child-development and day care programs be given more support, (2) that programs be developed to eliminate racism, and (3) that there be a reordering of national priorities, beginning with a guaranteed basic family income for all.

The consensus of the group conferences indicated that the community—from each individual to the most complex agency—was the starting point for integrated action. The government cannot solve all problems, and it is only with partnerships between the citizen, the private volunteer organizations, business, industry, and government that better achievement may be expected. A grand strategy is needed to improve the quality of life, and our visionaries need to become activitists.

Mrs. Robert Hartman
President-Elect

(Continued on page 70)

Pulse . . . of the doctor's wife

Congratulations–Auxiliary to the AMA–50 years young

From the President's Desk

As I come face to face with officers and chairmen representing the Auxiliaries of various states, I am aware of the highly composite collage the United States makes, with each state being individually unique, and having and solving its own set of problems.

I would like to make you aware of the many physicians' wives in such states as Wyoming, Montana, and the Dakotas who are as distant from one another as two to five hundred miles, making social gatherings as we think of them and enjoy them an impossibility, not to mention the state of Alaska with its bitter cold, and the Hawaiian state with the distances between the five separate islands. These different conditions make each state have their own distinct problems to solve, and this they do. (The National Auxiliary keeps a variety of programs to be in a position to serve all our states.) Furthermore, in many of our western states there is a concern for the great Indian tribes, to help record their culture; and also emphasis upon the culture of the gypsy tribes, which were originally from Egypt-Hindu origin; and the cultures of the Mexican and Oriental races, which all help make up the fabric of the United States, and which in our small way the auxiliaries influence.

As President, the conventions of the surrounding states of Kentucky, Michigan, Missouri, Iowa, Wisconsin, and Minnesota have been attended. You can be assured not only do we stand strong and sound among them, but in fact are considered leaders with them. Each state is unique, with its own distinct geographic, economic, and social flavor. Kentucky displays some of the charm of the Old South; Michigan with the strength of her strong industrial economic hold; Missouri has both, plus a great cross section of ethnic groups making it probably the most homogeneous; Iowa is still rural and friendly, with so many Indian names like Black Hawk County to remind us of another time and age; Wisconsin is influenced by the dairy industry and farms; and Minnesota with the famed Mayo Clinic, farms, mines, industries, and resorts. These states represent a small section of the Auxiliaries, moving, churning, learning, encouraging each other as we work out the same and different problems.

Changes about us pull and tug and question our purposes. In reality it is this point in reviewing our purposes that we realize how much we in Illinois, and our fifty states collectively, do to assist the State Societies in advancing medicine, public health and medical education; to aid in securing good medical legislation; to act as liaison between the medical profession and the general public and to cultivate friendly relations among physicians' families.

With this in mind we will look forward to working with you to recruit all members eligible for the Illinois State Auxiliary. Each auxiliary member in her own way can best use her talents and character in her own community through the Auxiliary, and together we can do so much. Do you know a better way to "get to know" your neighbor?

Lucia Martinucci

President

* * *

"Getting to Know You. . . ."

Auxilians enjoy a diversity of programs and meetings throughout the year. Recently *Lake County Medical Society* had as guest speaker Dr. Ahmed Nagib, who discussed the history of Oriental rugs, introduced to Western culture during the 15th Century.

Sangamon County Medical Society had a dessert meeting with a program on "What One Person Can Do: An Lac Orphanage, Saigon."

Will-Grundy County held a hobbies and crafts show in conjunction with a breakfast meeting, where members displayed many of their handiworks.

The Belleville Branch of the Auxiliary to the *St. Clair County* Medical Society earned $1500 for AMA-ERF with a "Fiesta Mexicana" dance. Guests were given play money (and allowed to purchase more) to be used in a "gambling casino" and for an auction for various prizes including nights on the town, autographed baseballs and hockey sticks, gift certificates, etc.



"My secret? For heartburn I always use 'Dicarbosil'."

Dicarbosil®
ANTACID

Write for Clinical Samples
ARCH LABORATORIES
319 South Fourth Street, St. Louis, Missouri 63102



What Is a Flag?

FLAGS everywhere—on our public buildings—in private homes—fluttering and billowing in the soft, summer breeze—flags everywhere—American flags!

Passersby, on the busy streets of the city, hurry on their way, minds intent on their own small affairs. They look idly at the flags, but do they really see them?

That oblong piece of cloth, with its bright dyes, is the visible symbol of America today—an America more precious, more wonderful than ever before, because the gifts it has given us are threatened, as never before, with loss and destruction!

The courage and strength of the pioneers—the pathfinders who met trials and hardship dauntlessly, in the days when we were beginning to be a nation—are in the red of its stripes!

The high and stainless purity of mind and motive—the whiteness of the souls of great men like Washington, Jefferson, Lincoln, and many others who strove selflessly to hold high their beliefs in the greatness of this nation, and who dedicated their lives to its service—are in the white of its stripes!

The truth that will not stoop to lie—the integrity of the principles that underlie our commonwealth, the unshakable faith and trust in God that has come down to us from those gone before, who have held high the light, that we might walk safely—are in the blue of its field of stars!

What is a Flag?

It is the soul of America—and it shall never die!

—Grace Bush.

★

Specialized Service
IN
PROFESSIONAL LIABILITY INSURANCE
is a high mark of distinction

THE
MEDICAL PROTECTIVE COMPANY
FORT WAYNE, INDIANA

Professional Protection Exclusively since 1899

CHICAGO AREA OFFICE: T. J. Pandak, J. C. Kunches, and L. R. Gannon, Representatives
T. J. Hoehn, Consultant
815 Commerce Drive, Suite 102, Oak Brook, Illinois 60521 (312) 325-7314
SPRINGFIELD OFFICE: W. J. Nattermann, Representative
426½ South Fifth Street, Springfield 62701 (217) 544-2251

Infections Following Trauma

(Continued from page 51)

tiated. After clindamycin therapy began he became afebrile within 2 days. The drainage site yielded no anaerobes after this therapy but did have small numbers of *Proteus mirabilis* and Enterobacter. He was discharged two weeks later in good health.

The two cases cited above illustrate the frequent failure of identification of anaerobic organisms as the cause of postsurgical infections. They also point out the failure of commonly used antibiotics in controlling these anaerobic infections. In both cases parenteral clindamycin was employed successfully. This agent is not yet F.D.A. approved as a parenteral drug; thus we presently recommend the use of Lincomycin, which has a similar spectrum against the anaerobic organisms.

III. Peritoneal Lavage in the Treatment of Peritonitis

Many studies have been published recently regarding the value of intraoperative or catheter irrigation of the peritoneal cavity with antibiotic solutions in the treatment of peritonitis. Most agree that instillation of antibiotics into the peritoneal cavity at the time of surgery does not decrease the incidence of intra-abdominal abscess formation. However, application of a mixture of 500 mg of kanamycin (KANTREX) and 50,000 units of bacitracin in 500 ml of normal saline solution to the fascia and subcutaneous tissues during abdominal wall closure has been of apparent benefit in limiting wound infections and thus is recommended. ◄

References

1. Chilimindris, C., Boyd, D. R., Carlson, L. E., Folk, F. A., Baker, R. J., and Freeark, R. J.: A critical review of management of right colon injuries. *J. Trauma* 11:651-660, 1971.
2. Gorbach, S. L., Nahas, L., Lerner, P. I., and Weinstein, L.: Studies of intestinal microflora. I. Effects of diet, age and periodic sampling on numbers of fecal microorganisms in man. *Gastroenterology* 53:845, 1967.
3. Martin, W. J., Gardner, M., and Washington, J. A., II: In vitro antimicrobial susceptibility of anaerobic bacteria isolated from clinical specimens. *Antimicrobial Agents and Chemotherapy* 1:148-158, 1972.
4. Moore, W. E. C., Cato, E. P., and Holeman, L. V.: Anaerobic bacteria of the gastrointestinal flora and their occurrence in clinical infection. *J. Infect. Dis.* 120:641-649, 1969.
5. Nichols, R. L. and Condon, R. E.: Antibiotic preparation of the colon: failure of commonly used regimens. *Surg. Clin. No. Amer.* 51:223-231, 1971.
6. Saksena, D. S., Block, M. A., McHenry, M. C., and Truant, J. P.: Bacteroidaceae: anaerobic organisms encountered in surgical infections. *Surgery* 63:261-267, 1971.
7. Zabransky, R. J.: Isolation of anaerobic bacteria from clinical specimens. *Mayo Clin. Proc.* 45:256-264, 1970.

Unemployment Compensation and the Solo Doctor

(Continued from page 62)

Reports of earnings and the amount of contributions due are to be filed quarterly with the State Department of Labor. The percentage rate of contribution due depends upon what the state calls the "loss experience factor." Since there is no loss experience on which to have a newly covered employer's rate, the state assigns a rate based on the amount of wages paid. Generally, the rate assigned is 2.7% with respect to the first $20,000 of covered wages paid during any calendar quarter. After three years of experience, the state reviews the employer's record—how many employees have left his employ and have drawn unemployment compensation. The State then re-assigns a new contribution rate.

The Unemployment Compensation contribution does not come out of the employee's salary. Rather, it is paid solely by the employer. The amount paid, however, is dependent upon the wages paid to the employee. Contributions are required for the first $4200 of wages paid to each employee.

In addition to the quarterly reports required by the State, an annual report must be filed with the federal government after the end of each calendar year and another tax paid to them.

While coverage under the Unemployment Compensation Act is new to most solo practitioners, it is here to stay. Failure to comply with reporting requirements leads to penalties. If you should have any questions regarding this tax, your management consultant, accountant or the State Department of Labor should be consulted. ◄

ANOTHER ISMS MEMBERSHIP PRIVILEGE
LOW-COST GROUP INSURANCE

GROUP DISABILITY PLAN

- **NEW**—Guaranteed renewable feature
- Sickness benefits to age 65
- Up to $250.00 weekly benefits

(PROTECT YOUR INCOME AND SECURITY)

GROUP SUPER MAJOR MEDICAL PLAN

- Up to $50.00 daily room and board
- Up to $25,000 for each accident or sickness
- In hospital and out of hospital expenses

(TRULY CATASTROPHIC PROTECTION)

FOR INFORMATION, ASSISTANCE & DETAILS CONTACT:

Administrators:

PARKER, ALESHIRE & COMPANY
ESTABLISHED 1901
Insurance

9933 N. Lawler Avenue
Skokie, Illinois 60076
Phone: 312-679-1000

Diabetes increases in Illinois

As one of 26 states taking part in a statewide diabetes screening program, Illinois found 46,417 cases over the 1970-71 period. This indicated an increase of 6,275 cases over the previous year, reports the Disease Detection Newsletter, published by the Disease Detection Information Bureau (DDib).

Unstable Angina

. . . The term "preinfarctional angina" is an unfortunate one since many, and possibly most, patients with unstable angina pectoris of recent onset neither develop myocardial infarcation nor die unexpectedly of a cardiac arrhythmia. The term "preinfarctional angina" is also unfortunate because its prognostic implications may lead cardiologists and surgeons to precipitate and, at times, ill-advised action. There are other terms which might be used for this disease: unstable angina, acute coronary insufficiency, threatened infarction, status anginosus, or the intermediate coronary syndrome. The patients in question are those who have a sudden onset of one or more anginal attacks a day from a previous background of good health or who have had a dramatic change in the symptomatic pattern of previously recognized coronary disease. The usual variety of anginal pain or discomfort lasts between 30 seconds and 30 minutes, and is related to effort; in patients with unstable angina, the attacks, in addition to being more frequent, are also often of longer duration and may occur at rest without an apparent precipitating event. ("Preinfarctional" Angina—A Need for an Objective Definition and for a Controlled Clinical Trial of its Management. **Circulation (Editorial)** Nov.) 1971, pg. 756)

When you prescribed Orinase®

(tolbutamide, Upjohn)

14 years ago, you had to rely on our experience.

An orally active hypoglycemic agent principally indicated in relatively mild, adult, maturity-onset, non-ketotic diabetes; also, as a supplement to insulin therapy in selected diabetic patients, it may effect a stabilization of labile diabetes and reduce insulin requirements. Certain patients intolerant to chlorpropamide therapy at usual therapeutic doses have subsequently been successfully managed with Orinase (tolbutamide).

Use in mild asymptomatic diabetic patients with abnormal glucose tolerance tests not responding to diet therapy may result in improvement of the glucose tolerance test.

Use in conjunction with phenformin is indicated when optimal control is not obtained with Orinase or phenformin alone.

Contraindications: Orinase alone is not effective in juvenile or growth-onset diabetes nor in unstable brittle diabetes where insulin therapy is required.

Orinase should not be used: when diabetes is complicated by acidosis, ketosis, or coma, or when a history of repeated bouts of acidosis or coma is obtained; in the presence of other acute complications such as fever, severe trauma, or infections; and in patients with severe renal insufficiency. Insulin is indicated in these circumstances.

Pregnancy Warning: The safety and usefulness of Orinase during pregnancy has not been established either from the standpoint of the mother or the fetus. Animal studies have demonstrated feticidal and teratogenic effects of doses of 1,000-2,500 mg./kg./day, but application to human subjects unknown. Therefore, Orinase is not recommended for the pregnant diabetic, and when administering Orinase to women of childbearing age, these facts should be borne in mind.

Precautions: Diagnostic and therapeutic measures necessary for optimal control with insulin are also necessary with Orinase. The patient on Orinase must be fully instructed: about the nature of his disease; how to prevent and detect complications; how to control his condition; not to neglect dietary restrictions, develop a careless attitude or disregard instructions relative to body weight, exercise, personal hygiene, and avoidance of infection; how to recognize and counteract impending hypoglycemia; how and when to test for glycosuria and ketonuria; how to use insulin; and to report to the physician immediately if he does not feel as well as usual.

Caution, very close observation, and careful adjustment of dose are necessary when: insulin is withdrawn during the trial period in order to avoid ketosis, acidosis, and coma; thiazide diuretics are administered which may result in aggravation of diabetic state and increased tolbutamide requirement, temporary loss of control, or even secondary failure; treating patients with impaired hepatic and/or renal function and debilitated, malnourished, or semistarved patients in order to avoid severe hypoglycemia which may require corrective therapy over several days; and treating patients with severe trauma, infection, or surgical procedures where temporary return to insulin or addition of insulin may be necessary. Response to tolbutamide is diminished in patients receiving therapy with beta blocking agents.

As some diabetics are not suitable candidates, it is essential that the physician familiarize himself with the indications, limits of application, and selection of patients for therapy.

Patients must be under continuous medical supervision, and during the initial test period should communicate with the physi-

Today you have your own.

If you're around 40 or 45, you've probably had quite a bit of clinical experience with Orinase.

Maybe as much as 14 years.

And that means you know quite a bit about it.

On the one hand, you know that diet and weight control are the initial and essential foundations for the management of adult-onset, non-ketotic diabetes. When these measures prove satisfactory, no additional therapy is indicated. On the other hand, you know that if these measures fail the addition of Orinase to the regimen can often help lower blood sugar. Orinase lowers blood sugar as effectively today as it did when you first prescribed it.

You also know the importance of close monitoring of the patient. Although uncommon, severe hypoglycemia may occur if the dosage is not tailored to suit his requirements.

In short, Orinase is a drug you're familiar with, and probably have confidence in.

And that may be the best recommendation Orinase can have.

Orinase®

0.5 g. tablets

(tolbutamide, Upjohn)

cian daily, and during the first month report at least once weekly for physical examination and definitive evaluation. After a month, examinations are recommended monthly or as indicated. Appearance of ketonuria, increase in glycosuria, unsatisfactory lowering or persistent elevation of blood sugar, or failure to obtain and hold clinical improvement indicate nonresponsiveness to Orinase (tolbutamide). Orinase does not obviate need for maintaining standard diet regulation. Uncooperative patients should be considered unsuitable for therapy. Prescriptions should be refilled only on specific instruction of physician. In treating mild asymptomatic diabetic patients with abnormal glucose tolerance, glucose tolerance tests should be obtained at three- to six-month intervals. Orinase is not an oral insulin or a substitute for insulin and must not be used as sole therapy in juvenile diabetes or in diabetes complicated by acidosis or coma where insulin is indispensable.

If phenformin is prescribed in combination with Orinase, appropriate package literature should be consulted.

Adverse Reactions: Severe hypoglycemia, though uncommon, may occur and may mimic acute neurologic disorders such as cerebral thrombosis. Certain factors such as hepatic and renal disease, malnutrition, advanced age, alcohol ingestion, and adrenal and pituitary insufficiency may predispose to hypoglycemia and certain drugs such as insulin, phenformin, sulfonamides, oxyphenbutazone, salicylates, probenecid, monamine oxidase inhibitors, phenylbutazone, bishydroxycoumarin, and phenyramidol may prolong or enhance the action of Orinase and increase risk of hypoglycemia. Orinase long-term therapy has been reported to cause reduction in RAI uptake without producing clinical hypothyroidism or thyroid enlargement and at high doses is mildly goitrogenic in animals. Photosensitivity reactions, disulfiram-like reactions after alcohol ingestion, and false-positive tests for urine albumin have been reported.

Although usually not serious, gastrointestinal disturbances (nausea, epigastric fullness, and heartburn) and headache appear to be dose related and frequently disappear with reduction of dose or administration with meals. Allergic skin reactions (pruritus, erythema, urticaria, and morbilliform or maculopapular eruptions) are transient, usually not serious, and frequently disappear with continued administration. Orinase should be discontinued if skin reactions persist. Recent reports indicate that long-term use of Orinase has no appreciable effect on body weight.

Orinase appears to be remarkably free from gross clinical toxicity: crystalluria or other renal abnormalities have not been observed; incidence of liver dysfunction is remarkably low and jaundice has been rare and cleared readily on discontinuation of drug (carcinoma of the pancreas or other biliary obstruction should be ruled out in persistent jaundice); leukopenia; agranulocytosis; thrombocytopenia; hemolytic anemia; aplastic anemia; pancytopenia; and hepatic porphyria and porphyria cutanea tarda have been reported.

Supplied: *0.5 g. Tablets*—bottles of 50, 200, 500, and 1,000, and cartons of 100 in foil strips.

For additional product information, see your Upjohn representative or consult the package insert.

The Upjohn Company, Kalamazoo, Michigan 49001 **Upjohn**

© 1971 The Upjohn Company JA71-1495 MED B-5-S LAO-6

Toxic Goiter And Pregnancy

(Continued from page 41)

rate of approximately 5-10 ug/Kg per day. Teleologically, this restricted potential for transplacental exchange is actually desirable because there would be no stimulus for the fetus to elaborate his own hormone if the mother were providing limitless quantities of TSH, T_4 and T_3. However, the relatively slow delivery of hormones across the placenta may complicate medical therapy for Graves' Disease since iodide as well as thiourylenes readily cross the placenta (and indeed can be concentrated within the fetus). Thus, intrinsic to any medical blockade of the maternal thyroid is the danger that one may also block thyroidal function in the fetus. Moreover, the relatively slow transplacental delivery of T_4 and T_3 to the fetus precludes assurance that one can administer sufficient replacement therapy for the mother to compensate for such blockade within the fetus. As you know, the fetus is extremely vulnerable to deprivation of thyroid hormone and especially so in the last trimester (when lack of thyroid hormone may retard neural and bone development).

In the face of these complexities, what has been our general policy? By and large, it is determined by the stage of pregnancy. In the first trimester, we are concerned with the danger of precipitating labor through the stress of anesthesia, so we avoid surgery. Moreover, since the fetal thyroid isn't conducting much hormonal biosynthesis during the first three months, we are not terribly worried about blocking the fetal thyroid and causing embryopathy. Our position is more flexible in the second trimester. In most instances, we advocate medical management and do this with small amounts of propylthiouracil. We monitor the dosage by frequent estimates of PBI (or T_4) and try to maintain PBI in the range of 8-12 ug%. This is to make certain the mother is not being overtreated (and by inference that we are not getting an excessive amount of blocking agent to the fetus). We can supplement this with added exogenous hormone, but such measures represent more psychological therapy for the doctor than physiological "safeguard" for the mother. In the second trimester, one could advocate surgery with equal conviction. However, in the third trimester, medical management again becomes the unequivocal treatment of choice because of the dangers via anesthesia, etc. Since this is also a period in which the developing fetus is exquisitely dependent upon adequate delivery of thyroid hormone, one should be particularly careful not to overtreat at this time. In addition to monitoring PBI, one also can aim for a BMR between +20 and +30 as the end point for effective medical treatment.

By and large, there are few immutables that govern the therapy of Graves' Disease during pregnancy, and decisions must be based on individualized factors. However, I do feel that our posture of advocating medical management in the first and third trimester and considering surgery if the diagnosis is made during the second trimester is consistent with the most prevalent practices elsewhere.

One final point warrants your attention if the mother has circulating LATS in association with her Graves' Disease. Plasma IgG can readily cross the placenta. As a consequence, a very intriguing phenomenon may arise and should be anticipated: That is the phenomenon of neonatal Graves' Disease. The pathogenesis is as follows: Maternal LATS, having crossed the placenta, may persist within the neonate for several weeks in accord with its biological half-life. The circulating LATS subjects the neonatal thyroid to persistent stimulation without normal feed-back regulation. Thus, the baby elaborates an inappropriate amount of thyroid hormone and can exhibit frank thyrotoxicosis. It is a self-limited disease and no cause for concern providing that the physician is alert to the possibility and appreciative of the underlying pathophysiology. ◄

References

1. Becker, W.F. and Sudduth, P.G.: "Hyperthyroidism and Pregnancy," *Ann. Surg.*, 149:867, 1959.
2. Herbst, A. L. and Selenkow, H. A.: "Hyperthyroidism During Pregnancy," *New Eng. J. Med.*, 273:627, 1965.

Too Many Doctors — Rx

(Continued from page 61)

more to fit the needs of any doctor. Some have the advantage of being located in familiar territory—that is, clinics and hospitals in real estate, medical instruments in equipment leasing. But most doctors prefer to entrust the care of their investments to tax-shelter specialists, who can analyze specific goals and balance the portfolio accordingly. ◄

Doctor's News

JOURNALISM AWARD WINNERS FETED—Eighteen newspaper, radio and television winners of 1971 ISMS Medical Journalism Awards were honored at the annual presentation banquet May 6 at the Playboy Towers Hotel in Chicago.

Winners in the eighth annual competition were chosen from among more than 200 entries by a panel of ISMS physicians and judges from the Publicity Club of Chicago.

A special Medical Journalism Excellence Award was presented to the St. Louis Globe Democrat for its outstanding coverage of medical and health topics throughout the year. The Missouri newspaper is the first recipient of the award—created to honor media in bordering states with substantial audiences in Illinois.

The awards were presented by Frank J. Jirka, Jr., M.D., ISMS president, and Willard C. Scrivner, M.D., president-elect.

METROPOLITAN AWARD WINNERS—Daily Newspapers: Chicago Sun-Times—William Braden, magazine feature, news story; Chicago Today—Dorothy Aiton, feature; Chicago Tribune—Ronald Kotulak, series.

Television: WMAQ, documentary; WBBM, news program.

Radio: WBBM, documentary series; WIND, discussion series.

NON-METROPOLITAN WINNERS—Daily Newspapers: Rockford Register-Star—Mrs. Sharen Johnson, feature; Aurora Beacon News—staff, news story; Kankakee Daily Journal—Mrs. Joan Hurling, series.

Weekly Newspapers: Hinsdale Doings—Mrs. Carol Hoag, series; Berwyn Life—Mrs. Judy Topinka, feature; Rantoul Press—Mrs. Katy Podagrosi, news analysis.

Radio: WMAY, Springfield, documentary; WJOL, Joliet, series.
program.

Television: WHAU, Peoria, editorial; WHBF, Rock Island, discussion

STATE TROOPERS AND TRAUMA PLAN SAVE LIFE—Two Illinois state troopers utilizing the new statewide trauma plan saved the life of a severely injured trucker. They were awarded the state's certificate of valor in ceremonies at the man's bedside at Evanston Hospital.

Otto Schneidau, 45, of 3717 Wayne St., Chicago, the truck driver, lost an arm and a leg when his truck overturned on Edens Expressway on February 3. State Troopers James Roney and Terry Ward arrived on the scene moments later and gave aid to Schneidau, who was trapped in the cab of the truck. The troopers remembered that Evanston Hospital was a state regional trauma center and directed the ambulance driver to bring the trucker there.

Using a radio link provided by the Evanston police, the troopers alerted the trauma center so that the necessary medical personnel and equipment were waiting when Schneidau arrived.

FOSTER G. McGAW GIVES $7 MILLION TO LOYOLA UNIVERSITY—President Raymond Baumhart, S.J., announced that, in appreciation, the University's 451 bed hospital in the Loyola University Medical Center at Maywood is to be designated the Foster G. McGaw Hospital of Loyola University of Chicago.

AGE AND INFLATION TAKE THEIR TOLL ON MEDICAL CARE—The average medical bill for a person 65 or older in fiscal year 1971 was $861, compared to $140 for a youth under 19, and $323 for a person between 19 and 64 years of age.

Public funds, mainly Medicare and Medicaid, covered two-thirds of the medical expenses of the aged, according to a report, "Medical Care Spending for Three Age Groups," in a recent issue of the Social Security Bulletin. An older person's out-of-pocket expenditure for health care dropped from more than one-half of his medical bill in 1966 (before Medicare and Medicaid) to about one-fourth of the total bill in 1971.

Because of higher prices and the increased use of services, however, the dollar amount they paid directly in 1971 was only slightly lower than in 1966—$225 in 1971, compared to $234 in 1966.

ILLINOIS' FIRST SCHOOL OF PUBLIC HEALTH—The state's first School of Public Health will open this fall with 25 master's degree students at the University of Illinois Medical Center Campus, Chicago. More than 300 students have expressed an interest in enrolling in the master's program during the school's first academic year.

HOSPITAL MAY APPEAL AUTOPSY DECISION—Judge Joseph M. Wosik, Circuit Court of Cook County, on May 31 rejected the petition of St. Joseph Hospital, Chicago, that he reconsider his decision of March 16 holding unconstitutional that portion of the 1965 statute allowing any member of the next of kin class to give a valid consent for medical autopsy. Attorneys for the hospital plan to appeal directly to the Illinois Supreme Court, since a constitutional question is involved. The Wosik decision applies only to this case and sets no controling precedent, but its publicity may spawn more lawsuits.

LICENSE HOLDER BOUND BY IMPLIED CONSENT LAW—The new Illinois Implied Consent Law (Section 11-501.1, Illinois Vehicle Code) soon to be effective, contains the provision for the person arrested for driving while intoxicated to obtain further chemical tests (blood tests) in addition to the required breath analysis for alcohol content of the blood. The law reads in part "If the arrested person is detained in the custody of the police after such test has been administered, the police shall, at the request of the arrested person, facilitate the prompt securing of an additional chemical test by a qualified person of the arrested person's choice and at his own expense as authorized by subsection (f) of Section 11-501."

Subsections (e) and (f) of Section 11-501, Illinois Vehicle Code, reads: "(e) When an unconscious person or person otherwise incapable of refusal is given a blood test at the request of a law enforcement officer under the provisions of this Chapter, only a physician authorized to practice medicine in all its branches, a registered nurse or other qualified person may withdraw blood, in a manner prescribed by the Department of Public Health for the purpose of determining the alcoholic content therein. (f) The person tested may have a physician authorized to practice medicine in all its branches, a qualified technician, chemist, registered nurse, or other qualified

person of his own choosing to administer a chemical test or tests, at his own expense, in addition to any administered at the direction of a law enforcement officer. The failure or inability to obtain an additional test by a person does not preclude the admission of evidence relating to the test or tests taken at the direction of a law enforcement officer."

If further information is desired, please direct correspondence to Dr. David R. Boyd, Chief, Division of Emergency Medical Services and Highway Safety, Illinois Department of Public Health, 535 West Jefferson, Springfield, Illinois 62706.

MOBILE X-RAY UNITS MAY COME TO HALT—The use of mobile equipment for x-raying members of the general population for tuberculosis and other chest diseases should be discontinued, according to a mass X-ray policy statement prepared jointly by the Federal Food and Drug Administration, the American College of Chest Physicians and the American College of Radiology.

COUNCIL AND COMMITTEE REORGANIZATION IS UNDERWAY—Recent action of the House of Delegates terminated all committees as an administrative procedure to: 1) allow the Board of Trustees to update the council and committee structure; 2) streamline councils and committees to make them more effective; 3) grant time in which challenges and problems can be oriented and assigned to appropriate groups. In the recent past, some committees were becoming involved in problems beyond the scope of their responsibility. In addition, there were substantial amounts of overlap. There was no attempt to de-emphasize any of the ISMS work or downgrade any level of involvement. On the contrary, ISMS will now become "problem oriented" and committees will be formed under the existing councils to meet challenges of the moment. In this manner, ISMS will be more immediately responsive to the needs of the membership and the public good. Some committees, as formerly constituted, performed well and fulfilled a perceived need. In these instances the committee will be re-established. But to accommodate the needed changes the House adopted the action cited above. Chairman of the Board Dr. William Lees states "I regret that the House of Delegates action was misinterpreted by some as an attempt to de-emphasize our work in certain areas. Nothing could be further from the truth. This is an attempt to have ISMS more deeply involved in meeting the challenges of today by having small select groups or committees of experts in a particular item formulate a position for ISMS."

MICHAEL REESE PSYCHIATRIST WINS TOP NATIONAL HONOR—The 1972 Distinguished Service Award of the American Psychiatric Association was presented to Dr. Roy R. Grinker, Sr., of Chicago's Michael Reese Hospital.

The award was presented by the APA President, Dr. Ewald W. Busse of Durham, N.C., who said Dr. Grinker was not only a great teacher and researcher but an "exposer of persiflage." Dr. Grinker, 72, was born in Chicago, educated at the University of Chicago and Rush Medical College.

ELLIS HONORED—Effie O. Ellis, M.D., special assistant to the AMA executive vice president, has been honored by the Chicago Pediatric Society and the U. of Illinois Alumni Assn. On May 17 Dr. Ellis was accorded honorary membership in the pediatrics society for her "significant contributions for the welfare of children." On June 1 she was recognized by the university as "Alumnus of the Year" for her "service to the government."

UROLOGICAL SOCIETY SELECTS NEW PRESIDENT—Lowell R. King, M.D., was elected president of the Chicago Urological Society at its annual meeting.

KLINGHOFFER GIVEN ROLAND R. CROSS AWARD—Max Klinghoffer, M.D., Elmhurst, Ill., a nationally recognized expert in emergency medical care, has been selected by the Illinois Public Health Assn. as the 1972 recipient of its Roland R. Cross Award of Merit. Dr. Klinghoffer is a member of the AMA Committee on Emergency Medical Services.

STAFF SERVICES FOR SPECIALTY SOCIETIES—As of June 19 the headquarters office of three specialty societies in Illinois were established within ISMS. This arrangement will allow the expeditious handling of administrative matters and effect economies in operation for the specialty groups. Those joining this venture include the Illinois Society of Internal Medicine, the Illinois Psychiatric Society and the Illinois Association of Ophthalmologists. Providing staff secretarial services will be Miss Marian Thiele, formerly a member of the ISMS Division of Public Relations.

Harvard Professor To Head Reese Department



Louis M. Sherwood, M.D., 35, of Harvard Medical School, has been named Chairman of the Department of Medicine and Physician-In-Chief at Michael Reese Hospital and Medical Center. He also was named Professor of Medicine in the Division of the Biological Sciences and The Pritzker School of Medicine of The University of Chicago.

Robert Zimmerman Appointed Director of ISMS Public Relations

Robert L. Zimmerman has been appointed director of public relations of the Illinois State Medical Society, it was announced by Roger N. White, executive administrator of the Society. He succeeds Robert W. Westerbeck, who joined the American Medical Association's communications division. Zimmerman was formerly manager of news services for the National Easter Seal Society for Crippled Children and Adults. Before that, his experience in the communications field included: director of public relations of the National Automatic Laundry and Cleaning Council; regional manager for McCann-Erickson Advertising Agency's public relations division and director of public relations for Calkins & Holden Advertising.



CMS Designates New Chief Administrator



Robert J. Lindley, Lombard, has been named chief administrative officer of Chicago Medical Society as of July 1, 1972. Mr. Lindley, a former executive of the Bank Marketing Association in Chicago, has been an executive director of the Society for the past two years. He is also the executive director of the Chicago Foundation for Medical Care, an affiliate of the Chicago Medical Society. Mr. Lindley will direct the Society's broad based program of service to its 6,700 physician members in Chicago and Cook County and to the public.

Abstracts of Board actions

(Continued from page 27)

2. Drs. Eugene Johnson, Casey; Allison Burdick, Jr., Chicago; Casper Epsteen, Chicago, and Carl Clark, Sycamore—Health Careers Council of Illinois.
3. Dr. William E. Adams, Chicago—Midwest Regional Library Association.
4. Dr. Carl E. Clark, Sycamore—Liaison to the Illinois Society of the American Association of Medical Assistants.
5. Dr. Edward Cannady, Belleville—Illinois Council on Home Health Agencies.
6. Dr. Newton DuPuy, Quincy—State Selective Service Advisory Commission.
7. Drs. Eugene T. Hoban, Eugene Johnson, Mather Pfeiffenberger and George Shropshear—Nominating Committee to select the Board of Directors for the Illinois Foundation for Medical Care.
8. Drs. Thomas R. Harwood, Chicago, and Edward W. Cannady, Belleville—ISMS representatives to the AMA National Homemakers Conference, May 25 and 26.

Revised Hospital Licensing Regulations

It was brought to the Board of Trustees' attention that hospitals have received notice of hospital licensing act revisions requiring psychiatrists who treat patients in a psychiatric hospital or in a psychiatric unit of a general hospital to have completed a three-year residency in psychiatry. By official action, the Board stated that this regulation is impractical and unenforceable and referred the problem to its new Health Care Priority Committee.

Tenure and Redistricting

The Board directed the ad hoc committee that will study the demography and districting of ISMS to also consider:

1. Establishing tenure limitations for officers and trustees.
2. Broadening the Society structure by providing for a vice-Secretary-Treasurer and Associate Trustees.

The committee is requested to submit its recommendations to the Board no later than January, 1973.

Illinois Council for Continuing Medical Education

Bylaws for the new Illinois Council for Continuing Medical Education were approved by official action of the Board, which also recommended that representatives of the University of Illinois branches in Peoria and Rockford be included on the Council's Board of Directors.

Illinois State Fair

ISMS and the Comprehensive Health Agency in Illinois will co-sponsor and share the cost of an exhibit at the 1972 Illinois State Fair.

Laboratory Proficiency Testing

The Board agreed to cooperate with the Illinois Department of Public Health to encourage members having private office laboratories to participate in upgrading procedures. Voluntary enrollment of physicians in a laboratory proficiency testing program was endorsed as part of the program. By official action, the project was referred to an appropriate ISMS council to develop questions to be used in a survey proposed by the Public Health Department. Purpose of the poll is to determine the number of exempt laboratories and the advisability of establishing mandatory testing.

AETNA Insurance Company Communications

It was reported that the Aetna Insurance Company has been sending letters to Illinois policy-holders offering legal services in fee disputes with physicians. In a recent meeting with Aetna officials ISMS officers explained the concept of peer review and requested them to discontinue making such proposals to private patients. Aetna representatives agreed to discuss the ISMS request with their home office. By official action, the Board voted to buttress efforts already made by requesting the company to cease and desist from sending inflamatory letters affecting the sensitive area of doctor-patient relationship and to request the company to utilize the peer review mechanism available. Further, the Board suggested that if the insurance company is contracting for physicians' services, negotiations should be bilateral and include physician input. Retraction of letters already sent was recommended.

Conference on School Health

ISMS will again co-sponsor a Conference on School Health to be conducted in December in Springfield. The Board guaranteed to underwrite up to $500 in expenses if necessary.

Financing for IFMC

The Board approved an IFMC request to establish a line of credit in the form of a loan, part of which monies will be used to repay ISMS for the monies loaned the Foundation as start-up funds.

Publications Committee

The Board approved the following recommendations of the Publications Committee:

1. Two pages of editorial space monthly in the Illinois Medical Journal to be provided to the Woman's Auxiliary to replace the communications medium lost when Pulse was discontinued.
2. Authority to negotiate a contract with United Media Associates, a space representation firm, to obtain national advertising for the Journal.
3. Development of a section in the Journal for the Physicians Placement Service to alert members to practice opportunities.
4. A newsletter to replace Pulse which would be mailed first class on the second and fourth Friday of each month. After initial mailings, members will be requested to indicate whether or not they want to stay on the mailing list.

Health Manpower

The Board of Trustees agreed that ISMS should participate in Phase I of the Illinois Hospital Association's plan to study institutional licensing or credentialing of health personnel, exclusive of physicians, nurses, dentists and pharmacists. It was emphasized that Phase I would involve a government grant for discussion and study and would not include operations of any sort.

Hill-Burton Hospitals and the Needy

In a recent court decision, it was ruled that hospitals which have received funds under the Hill-Burton Act are obligated to provide free services up to 25% of their net income or five percent of their operating costs. Dr. Bruce Flashner, Medical Director of the Illinois Department of Public Aid, warned the Board that unless remedial legislation is passed, physicians will be feeling the effect of this ruling soon. It was reported that the Hospital Association has proposed counter legislation and the ISMS Board voted to support the Hospital Association's position.

Insurance Privileges for Members moving away

The Board approved a recommendation that the ISMS Bylaws provide a membership classification that would permit members moving out of state to continue their insurance until re-established. By official action, the matter was referred to the Committee on Constitution and Bylaws.

Treatment of Minors for Drug Abuse

The Board authorized Dr. Joseph Skom to appear with counsel of the Illinois Department of Mental Health, not as a party to the hearing, but in support of the position of the IDMH in the treatment of minors for drug abuse.

Mental Health Budget

The Board approved, in principle, support for the Illinois Department of Mental Health budget, which includes an increased amount of money to attract more fully licensed physicians to state facilities as well as expanded purchase of care programs.

Methadone Maintenance

On recommendation of the Council on Mental Health and Addiction, the Board endorsed the following concept:

Regulations should make it impossible for an individual physician to treat or maintain patients on methadone, unless counseling and laboratory services also are furnished and available on a daily basis. If a physician is approved for the methadone program by the Department of Justice, Bureau of Narcotics and Dangerous Drugs, and the FDA, then he should also be approved by the Illinois Drug Abuse Program. Provision should be made for enforcement of the regulations through an investigative activity of IDAP, with assistance from other departments.

Nitroglycerin Tablet Packing

On recommendation of the Council on Environmental and Community Health, the Board endorsed the following procedures for storing and dispensing nitroglycerin tablets:

1. Tablets may be dispensed only in glass vials with screw caps.
2. No label may be placed inside the container.
3. The smallest vial that will hold the quantity to be dispensed should be used —there must be a minimum amount of cotton filler.
4. Do not strip package.

Nutrition Conference

ISMS will again co-sponsor a Nutrition Conference with the Illinois Nutrition Committee. The 1972 Conference will be held in October in Carbondale.

Governmental Affairs

The Board approved the concept of certification of hearing aid dealers and of working with the Illinois Hearing Aid Dealers Association in support of this legislative proposal.

The Board concurred with the Governmental Affairs Council that HB-493 (Health Facilities Authority Act) that ISMS objections should be made known to the state senators, but that no all out effort be made to defeat the bill.

The Board reaffirmed the position of the 1972 House of Delegates regarding Health Care Planning in Illinois. These instructions mandate ISMS to oppose any state-wide health care plan that does not allow for sufficient physician input at the local level.

If changes in the Illinois law regarding HMOs are necessary, it is recommeded that the Voluntary Health Services Act (Chapter 32, Sec. 596, Illinois Revised Statutes, 1971) should be revised.

The Illinois Delegation to the AMA has been requested to submit the following resolution to the AMA in June:

"Resolved that the AMA explore the possibility of utilizing the judicial process to protect physician rights to practice their profession without unwarranted governmental interference, and to prevent further unnecessary government encroachment into the Health Care field, and

"Resolved that the AMA direct that a review of unnecessary government interference in the medical field be made by legal counsel to determine if class actions would be a viable means of halting the continued unnecessary government action."

Permit Doctors

The Board voted to oppose HB-4216, which would amend the Medical Practice Act to eliminate limited license physicians because the bill was considered premature.

On the other hand, the Board agreed to support SB-1530 which would allow the Department of Mental Health to replace permit physicians no later than 1975.

Psychologist Reimbursement

The Board instructed the Governmental Affairs Division to attempt to have a series of psychologist reimbursement bills referred to the Health Care Licensure Committee and oppose their passage in the legislature.

Drugs in the Treatment of Depression

(Continued from page 47)

depression, the high spontaneous improvement rate, and the likelihood of recurrence after recovery for certain patients.

Current treatments are major improvements over previously available methods, but a "cure" is not to be expected, particularly for a small group of chronic depressives. The available antidepressant drugs do not "cure" depression; they ameliorate the patient's symptoms and facilitate his personal adjustment and social adaptation. We can anticipate that further advances in drug therapy will be forthcoming. ◄

References

Fink, M.; Klein, D. F.; and Kramer, J.C. 1964. Clinical efficacy of chlorpromazine-procyclidine combinations, imipramine and placebo in depressive disorders. *Psychopharmacologia* 5:27-36.

Klein, D. F. 1964. Delineation of two drug-responsive anxiety syndromes. *Psychopharmacologia* 5:397-403.

Klerman, G. L. and Cole, J. O. 1965. Clinical pharmacology of imipramine and related antidepressant compounds. *Pharmacol. Rev.* 17:101-141.

Klerman, G. L. and Paykel, E.S. 1969 Drugs and the Brain P. Black (Ed.) Baltimore: Johns Hopkins Press "Clinical Use of Antidepressant Drugs" pp. 185-201.

Klerman, G. L. and Paykel, E. S. 1970 Principles of Psychopharmacology W.G. Clark (Ed.) New York: Academic Press "The Tricyclic Antidepressants" pp. 627-642.

Klerman, G. L.; Paykel, E. S.; and Tonks, C. M. 1969 Current Therapy, 1969 H.F. Conn (Ed.) Philadelphia: W.B. Saunders "Depression" pp. 731-736.

Kuhn, R. 1958. The treatment of depressive states with G22355 (Imipramine hydrochloride) *Am. J. Psychiat.* 115:459-464.

Overall, J.E.; Hollister, L.; and Pennington, V. 1966. Nosology of depression and differential response to drugs. *JAMA* 195:946-948.

Sargant, W. 1961. Drugs in the treatment of depression. *Brit. Med J.* 1:255-227.

Schildkraut, J.J. 1964. The catecholamine hypothesis of affective disorders. A review of supporting evidence. *Am. J. Psychiat.* 122:509-522.

Wittenborn, J.R.; Plante, M.; Burgess, F.; and Maurer, H. 1962. A comparison of imipramine, electroconvulsive therapy and placebo in the treatment of depressions *J. Nerv. Ment. Dis* 135:131-137.

APPROVED AVAILABLE NOW!
ISMS
MALPRACTICE INSURANCE

Professional Liability Insurance Program
Approved for Members
REGARDLESS of AGE or SPECIALTY

Protect Doctor's Integrity
Company will settle no claims without insured member's approval. Nuisance claims *will* be fought.

Improve Legal Climate
Company will retain outstanding defense counsels who are experts in professional-liability cases.

Provide Market Stability
Company will maintain an available market. Participation by the members is needed to assure this market.

Keep Members Informed
Company will tell members how to prevent claims . . . keep them aware of latest legal developments in malpractice field.

ISMS Supervision And Control
Premiums to reflect only the loss experience of ISMS. All questionable underwriting cases to be reviewed by ISMS. A UNIQUE FEATURE

FOR INFORMATION, ASSISTANCE & DETAILS CONTACT ADMINISTRATORS:

PARKER, ALESHIRE & COMPANY
ESTABLISHED 1901
Insurance

9933 N. Lawler Avenue
Skokie, Illinois 60076
Phone: 312-679-1000

Guest Editorial

What should a teaching case teach?

The medical profession needs to re-evaluate its concept of what is a teaching case.

For the past decade the handwriting has been on the wall. We have suspected that sooner or later retroactive disallowances for diagnosis or treatment deemed unnecessary would be instituted. That time has been here and it is about gone. Now preadmission certification is an everyday occurrence.

There is no problem with the paying private patient who has no insurance coverage. As a rule, only needed studies are performed. Today, however, such a patient is rare because almost everyone has insurance.

But somehow, hospitals having residency training programs in medicine and surgery for years have taken for granted that the resident should be permitted to order any test in the book for the non-paying patient. This is especially true if the test is in any way related to his illness. Instead of teaching our in-hospital residents how to examine and study the patient, we have allowed additional laboratory tests.

With the shortage of funds for welfare, Title XIX patients (Medicaid)—in fact, for all patients where third-party payment is involved—the time is here when the dollar must cover more people. Therefore it is necessary to perform only needed procedures. Along with this, the ambulatory center should be the locale for doing all indicated preadmission tests and consultations.

In Illinois the Hospital Admissions Surveillance Program (HASP) is attempting to help make the dollar cover more people. This program is patterned after other successful programs in other areas of the country.

With a tight ship, the resident can not only be taught medicine and surgery, but also will learn to be knowledgable and conscious of the cost of medical care.

A teaching case should not only be involved in arriving at a diagnosis and effecting proper treatment for a certain patient. This should be the opportunity to teach our residents how to arrive at a diagnosis and render treatment in the most efficient and economical manner.

W. C. Bornemeier, M.D.

CLASSIFIED ADVERTISING

Positions & Practice Opportunities

UNUSUAL OPPORTUNITY FOR PHYSICIANS who prefer not to maintain an office to join a rapidly growing fee-for-service group in the Emergency Department of Chicagoland hospitals. Flexible work schedules, 24-48 hours weekly. Prefer surgeons, general practitioners with experience in traumatic medicine, or those specifically interested in high standard Emergency Care. Group is expanding, developing teaching programs. Excellent facilities, automated billing and collecting service, opportunity for research in emergency procedures and programming. Ideal for physician desiring high remunerative compensation for circumscribed work. Address reply to: Medical Emergency Service Associates (MESA), S.C., 111 North Addison, Elmhurst, Illinois 60126. 832-4504.

OPENINGS FOR PHYSICIANS in Psychiatry, Internal Medicine or General Medicine. The Illinois Department of Mental Health invites physicians to apply for challenging positions in its mental health facilities. A comprehensive program of mental health and retardation involving community and inpatient programs is established throughout the State.

Openings are available for physicians who qualify for an Illinois License with approved training in Psychiatry, Internal Medicine or General Medicine.

Salaries for Illinois-licensed physicians range from $24,000 to $41,000 depending upon professional qualifications, experience and capability of assuming increasing professional responsibilities, i.e., Board Certified or Eligible Physician, commencing salary $28,308.

Liberal benefits include life and health insurance, annual and sick leaves, retirement and social security.

Interested doctors should write to Mr. Bernard McLaughlin, Medical Staff Employment Administrator, Illinois Department of Mental Health, 160 North LaSalle Street, Chicago, Illinois 60601, or call collect—area code 312, 793-2748 or 2749, hours 9 a.m. to 4:30 p.m.

WANTED: OB-GYN, SURGEON and INTERNIST for nine man group. Thirty miles southwest of Chicago, excellent hospital, housing and schools. $30,000 guarantee first year. Write to Box Number 782, c/o Illinois Medical Journal, 360 N. Michigan Ave., Chicago, Illinois 60601.

FAMILY PRACTITIONERS, Fairfield, Illinois 6000 population—Excellent schools and recreational facilities for your family. Write or call collect: Jerry Vaughan, Box H, Fairfield, Illinois 62837—Telep. (618) 842-2167.

IMMEDIATE OPENING: INTERNIST or GENERAL PRACTITIONER to join six man multi-specialty group in northeastern Wisconsin. Excellent professional opportunity to practice in a friendly community, only two actively practiticing physicians (General Practitioners) in the community outside of our Clinic. Salary commensurate with training and experience first year and then full partnership. Ideal, safe small city living for the family on scenic Lake Michigan with excellent fishing, boating and hunting. All this and still only 1½ hours drive to Milwaukee or 45 minutes to Green Bay or lovely Door County. For complete details contact Robert E. Myers, M.D., Garfield at 23rd. Two Rivers, Wisconsin 54241.

WANTED ASSOCIATE IN GENERAL PRACTICE. Join 2 men in established incorporated practice in large northern suburb of Chicago. Excellent schools and cultural advantages. Dealing primarily in internal medicine. No OB or Surgery. Practicing in 500-bed teaching hospital. Contact Bernard Berne, M.D., 603 Main Street, Evanston, Illinois 60202.

IMMEDIATE OPENING for OB-GYN, Internal Medicine, and Orthopedic specialties to establish successful practice with 14-man multi-specialty group. Excellent group benefits; pension plan; modern clinic facilities; progressive community with excellent educational system including two colleges; city population 35,000; good recreational facilities; each specialty must be board eligible or certified; young man with military obligation completed. Contact: Business Manager, The Manitowoc Clinic, 601 Reed Avenue, Manitowoc, Wisconsin 54220.

PSYCHIATRIC STAFF—Requirements of 3 year residency training to Board Certified. $26,000 to $36,300 depending on qualifications and experience. Excellent Michigan Civil Service fringe benefits. Smog free, peaceful, cultural, summer-winter vacationland community. College town. Near Interlochen National Music Camp. 1400 bed progressive psychiatric hospital. J.C.A.H. approved. 3 year psychiatric residency program. Contact M. Duane Sommerness, M.D., Room 321, Traverse City State Hospital, Traverse City, Michigan 49684. An equal opportunity employer.

PHYSICIAN FOR HEALTH SERVICE STAFF For September 1, 1972 or earlier. 40 hours per week plus night duty every 16th night. One month vacation and other benefits. Equal opportunity employer. Salary to $26,250 per year. Illinois License required. Appreciate full information first letter. L. M. Hursh, M.D. Director Health Services, University of Illinois, Urbana, Illinois 61801.

ASSOCIATE WANTED: GENERAL PRACTITIONER for extremely busy solo practice. 1970 gross income well over six figures. Ideal location in small Illinois community. New 100-bed hospital. 45 minutes from downtown St. Louis and 15 minutes from 26,000 acre Lake Carlyle. Excellent schools, churches, and recreation facilities. Salary arrangement or guaranty first year, leading to eventual buy-in. Write to Box Number 800, c/o Illinois Medical Journal, 360 N. Michigan Ave., Chicago, Illinois 60601.

GENERAL PRACTITIONER OR INTERNIST for large University Health Service. Salary per qualifications. Illinois license required. Fine facilities, good geographical location. L. W. Akers, Director, N.I.U., DeKalb, IL. 60115.

CLINICAL DIRECTOR (Psychiatry). Milwaukee County Mental Health Center. We are a community oriented center providing out-patient, in-patient and partial hospitalization for adults and children, and also providing community psychiatric clinics located in 6 catchment areas. Supervise psychiatric, neurological, medical and related services. Requires completion of approved 3 year residency in psychiatry, eligibility for Wisconsin license and a total of 7 years' experience or training in psychiatry. For further information contact: George E. Currier, M.D., Asst. Director, Mental Health, 9191 Watertown Plank Rd., Milwaukee, Wis. 53226. (414) 258-2040, Ext. 3440.

GENERAL PRACTITIONER or **INTERNIST** for expanding group practice plan. Regular hours. Salary negotiable. Tax shelter plan. Illinois licensure required. Progressive city of 90,000 with cultural and recreational advantages. Write to Box Number 801, c/o Illinois Medical Journal, 360 N. Michigan Ave., Chicago, Illinois 60601.

PHYSICIAN to direct University Health Program. 18,000 students. Interesting work in an excellent community. Modern health facility. Salary competitive and negotiable. Fringe benefits. For further information send vitae to: Leo H. Frigo, M.D., University Health Service, Illinois State University, Normal, Illinois 61761 or call (309) 438-8655.

CLINICAL DIRECTOR to administer the medical aspects of a progressive 1,200 resident facility for the mentally retarded. Will be responsible to the Superintendent for all aspects of the clinical service and supervision of staff. Specialists in pediatrics, neurology or internal medicine will be preferred. Board certification is desirable Eligibility for Michigan licensure required. Salary ranges from $29,211 to $36,372 with starting salary dependent on qualifications. Housing currently available at nominal cost. Excellent fringe benefit and retirement program through Michigan's outstanding Civil Service. The facility is located in a small, progressive community in lower Michigan which provides a style of life many would like to recapture yet it is close enough to cities such as Saginaw, Flint and Detroit to provide the shopping, entertainment and cultural life of the big city. To apply send vitae to the Superintendent, Caro State Home and Training School, Caro, Michigan 48723. An Equal Opportunity Employer.

MEDICAL SERVICE STAFF PHYSICIAN—Board certification in Internal Medicine preferred. 216-bed modern general hospital with active medical and surgical services. Salary dependent upon qualifications. Excellent fringe benefits. Can pay moving expenses. License any state required. Equal Opportunity Employer. Contact Hospital Director, Veterans Administration Hospital, Fort Wayne, Indiana 46805, or call (219) 743-5431, Extension 310.

PHYSICIANS: Bd. Certified or eligible—two internists with interest in cardiology or pulmonary diseases; and one orthopedic surgeon. Also, physician for outpatient unit. 229-bed hospital with coronary care and soon to be activated respiratory care units. Hospital in small community Michigan Upper Peninsula offering ideal family living, a superior school system, and all-seasons sports vacationland. Full staff of highly qualified physicians, 80% Bd. Certified. Lincensure, any state. U.S. citizenship. Salary based on qualifications. Excellent fringe benefits. Non-discrimination in employment. Contact Chief of Staff, VA Hospital, Iron Mountain, Michigan 49801, Phone 906-774-3300.

BLUE SHIELD REPORT FOR *Illinois Physicians*

Good Neighbors

In a recent speech, Ned F. Parish, the president of the National Association of Blue Shield Plans, likened Blue Shield and the physician community to "neighbors with a common goal—that of contributing to better health care."

Parish said that Blue Shield's success in providing for a better health care delivery and financing system "rests to a great extent on how we two, as neighbors in a common cause, get along."

Through strong, realistic professional relations, he said, "both medicine and Blue Shield can establish a healthy respect for each others 'property rights,' . . . and find out how we can best cooperate to achieve our goals."

In the beginning, he said, Blue Shield was organized by physicians, and had it not been for some extraordinarily dedicated doctors, the movement would not exist today.

"When I run across a physician—or a group of physicians—who feels Blue Shield is not his neighbor, but rather his tenant, my first reaction is one of dismay, because such an attitude is a grave injustice to the image of those early physicians who made many personal and professional sacrifices so that the public could have better access to medical care," Parish said.

Today, he said, there are many in the medical profession who feel that "a once friendly, trusted neighbor has turned on it. And Blue Shield, one of whose purposes it is to function as the public's representative in the area of medical care, sometimes finds hostility in the medical community."

In recent years, he said, it has become evident that public attitudes have also changed. "Young people, many born under Blue Shield coverage but never perceiving of us as a social movement, became more inquisitive and articulate. If Blue Shield could not deliver as they felt it should, and could not hold down costs to reasonable limits, its future role was strongly questioned."

One manifestation of physician discontent, he noted, has been the emergence in some parts of the country of Foundations for Medical Care.

While he indicated that he was not opposed to the Foundation concept, Parish said, "Foundations can be most useful to the public and to medicine if they work primarily in the area of peer review through Blue Shield and other carriers."

On the other hand, Parish noted that there are Foundations cooperating with Blue Shield in utilizing the best of both capabilities to help strengthen the private sector.

"We can succeed," he concluded, "because both Blue Shield and medicine have a great deal to offer each other in building a stronger health care system. The challenge is not to separate these resources, but to try and solidify our collective front through a little better understanding of the mutual contributions each has made and the proper roles for each to play."

Our New Home

Finishing touches are being put on the new home of Blue Cross-Blue Shield located at Two Illinois Center (east side of Michigan Avenue at Lake Street), Chicago.

Our present building which we have occupied for four years is too small to meet rising needs and demands of Blue Shield's growth.

The new building brings together under one roof a number of important functions formerly carried out by our 2,500 employees housed in five different locations. Our new facilities will allow us to consolidate our Plan activities and improve our service to you.

The thirty-story modern structure will be ready for occupancy about the middle of October and Blue Cross-Blue Shield will occupy thirteen of the thirty stories.

The structure designed by Chicago architect Mies Ban Der Rohe is built of bronze anodized aluminum and glass. The building's central core construction presents maximum useable space, free of columns.

The exact date we move from our present Plan office to the new Blue Cross-Blue Shield building has not yet been set. We will keep you informed.

(This is not an advertisement)

ASK BLUE SHIELD

• • • ABOUT MEDICARE

EFFECT OF PHASE II CONTROLS ON ALLOWABLE CHARGES UNDER PART B MEDICARE

The allowable charge, on which Medicare Part B payment is based, may not exceed the lowest of (1) the physician's usual charge for the service, (2) the customary charges in the locality for similar services, or (3) the charge applicable for comparable services, under comparable circumstances to the subscribers of the carrier.

Under present SSA regulations, allowable charges are updated annually to take into account the actual charges physicians have billed for covered services in the immediately preceding calendar year. The revised allowable charge levels go into effect on July 1st of each year or as soon thereafter as they can be incorporated into the carrier's payment system. Thus, for the 12-month period beginning July 1, 1972, the allowable charges will be calculated from actual charges for calendar year 1971.

However, because of a ruling by the Price Commission, *only 40% of these calculated increases in allowable charge levels* can be recognized for the 12-month period beginning July 1, 1972.

The ruling of the Price Commission is that the Medicare allowable charges in effect on November 13, 1971, must be considered as *base prices* for Phase II purposes, and that, as a result, they may not be increased by more than 2.5 percent in the aggregate during the fiscal year beginning July 1, 1972. Based on actual increases in physicians billings in calendar year 1971, the charges allowed under the Medicare program for the 12-month period beginning July 1, 1972, would have been increased by about 6.2 percent in the aggregate. Therefore, to implement the Price Commission's ruling, only 40 percent (2.5 is about 40 percent of 6.2) of the increases that would ordinarily have been allowed will be recognized in calculating allowable charges for the fiscal year beginning July 1, 1972.

EXAMPLES OF SKILLED AND NON-SKILLED NURSING SERVICES

Skilled Nursing Services

Skilled nursing services include but are not limited to the following:

1. Intravenous or intramuscular injections and intravenous feeding. (Injections which can usually be self-administered—for example, the well-regulated diabetic who receives a daily insulin injection—do not require skilled services.)
2. Levine tube and gastrostomy feedings.
3. Naso-pharyngeal and tracheotomy aspiration.
4. Insertion or replacement of catheters.
5. Application of dressings involving prescription medications and aseptic techniques.
6. Care of extensive decubitus ulcers or other widespread skin disorders.
7. Heat treatments specifically ordered by a physician as part of active treatment and which require observation by skilled nursing personnel to adequately evaluate the patient's progress.
8. Initial phases of a regimen involving administration of medical gases.
9. Restorative nursing procedures, including the related teaching and adaptive aspects of skilled nursing, which are part of active treatment and require the presence of licensed nurses at the time of performance, e.g., teaching the skills and facts necessary for understanding adherence to a regimen such as bowel and bladder training.

Non-Skilled Services

Unskilled or supportive services are those that can be learned and performed by the average nonmedical person, and include but are not limited to the following:

1. Administration of routine oral medications, eye drops, and ointments.
2. General maintenance care of colostomy or ileostomy.
3. General methods of treating incontinence, including use of diapers and rubber sheets.
4. Routine services in connection with indwelling bladder catheters. (This would include emptying containers and cleaning them, clamping tubing, and refilling irrigation containers with solution.)
5. Changes of dressings in noninfected postoperative or chronic conditions.
6. Prophylactic and palliative skin care, including bathing and application of creams, or treatment of minor skin problem.
7. Use of heat for palliative and comfort purposes.
8. Administration of medical gases after initial phases of teaching the patient to institute therapy.
9. General supervision of exercises which have been taught to the patient.
10. General maintenance care in connection with a plaster cast.
11. Routine care in connection with braces and similar devices.
12. Assistance in dressing, eating, and going to the toilet.

(This is not an advertisement)

IMJ illinois medical journal

volume 142, number 2 August, 1972

staff

editor Theodore R. Van Dellen, M.D.
managing editor Richard A. Ott
assistant editor Joyce Sevits
executive administrator Roger N. White

clinical articles

Peptic ulcer in air traffic controllers
Richard R. Grayson, M.D. 111

The relationship of degenerative diseases to blood pressure
Sol K. Robinson, M.D. 116

Maternal death study case report No. 6
Robert R. Hartman 120

The value of the screening program on the incidence of sickle cell disease
Albert Sion, M.D. and Morris T. Friedell, M.D. 124

Elective interval appendectomy for recurrent right lower quadrant pain
George W. Abatso, M.D. 131

special article

Aspects of nutritional status of pre-school children in the United States, 1968-1970
George M. Owen, M.D. 156

Society of critical care medicine
David Allan, M.D. 128

trauma center

A new health professional: the trauma coordinator
Kenneth D. Mains, USN, David R. Boyd, M.D.C.M. and Bruce A. Flashner, M.D. 158

surgical grand rounds

Mesenteric embolus 121

features

the presidents page 96
new pharmaceutical specialties 102
clinics for crippled children 119
editorial 129
the view box 130
what goes on 134
ekg of the month 135
the cooper quiz (a new feature) 136
practice management 138
membership forum 140
doctors news 143
american association of medical assistants—illinois society 150
pulse of the doctors wife 154
obituaries 160

(cover by Mike White)

Microfilm copies of current as well as some back issues of the *Illinois Medical Journal* may be purchased from Xerox University Microfilms, 300 North Zeeb Road, Ann Arbor, Mich. 48106.

Published monthly by the Illinois State Medical Society, 360 N. Michigan Ave., Chicago, Ill., 60601. Copyright, 1972, The Illinois State Medical Society.

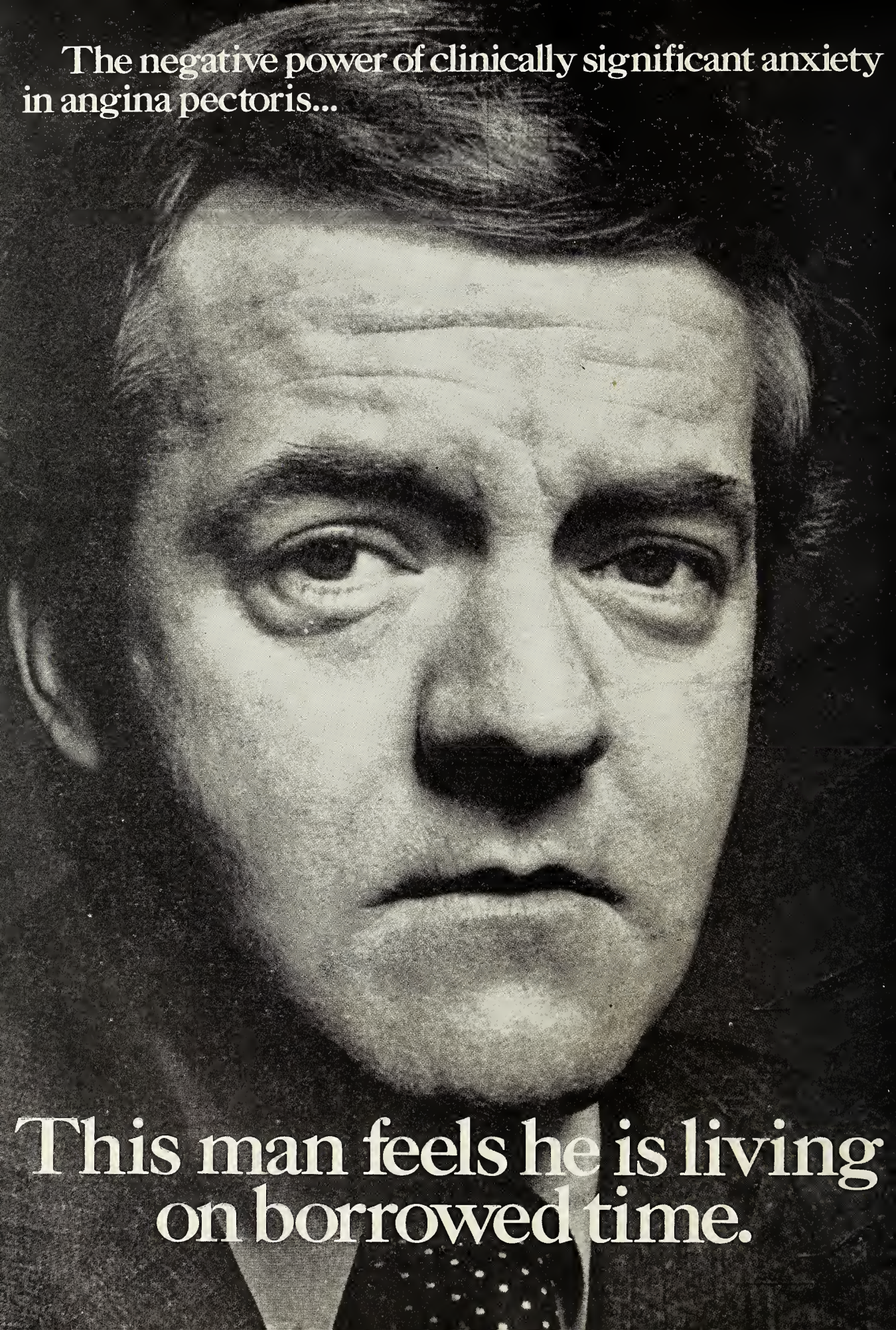
Subscription $5.00 per year, in advance, postage prepaid, for the United States, Cuba, Puerto Rico, Philippine Islands and Mexico. $7.50 per year for all foreign countries included in the Universal Postal Union. Canada $5.50 U.S. Single current copies available at 75c.

Second class postage paid at Chicago, Ill. and at additional mailing offices. When moving please notify Journal office of new address including old mailing label with notification, if possible. POSTMASTER: Send notice on form No. 3579 to Illinois State Medical Society, 360 N. Michigan Ave., Chicago, Ill. 60601.

Pharmaceutical advertising must be approved by the ISMS Publications Committee. Other advertising accepted after review by Publications Committee or Board of Trustees. All copy or plates must reach the Journal office by the fifteenth of the month preceding publication. Rates furnished upon request.

'Original articles will be considered for publication with the understanding that they are contributed only to the Illinois Medical Journal. The ISMS denies responsibility for opinions and statements expressed by authors or in excerpts, other than editorial or allied views or statements which reflect the authoritative action of the ISMS ar of reports on official actions, policies or positions. Views expressed by authors do not necessarily represent those of the Society; any connection with official policies is coincidental.

REGISTERED AIA MEDIA DATA FORM


The negative power of clinically significant anxiety in angina pectoris...
This man feels he is living on borrowed time.

During anginal attacks, patients may suffer intense apprehension. More frequently, however, they experience a continuing sense of less severe but nonetheless disproportionate anxiety.

Reduction of such clinically significant anxiety is important, since undue emotional stress may precipitate further anginal episodes.

Adjunctive Librium (chlordiazepoxide HCl) may be especially suitable for relief of clinically significant anxiety and emotional tension in anginal patients because of its generally prompt therapeutic effectiveness and wide margin of safety. In a recent double-blind randomized study,* Librium (chlordiazepoxide HCl) was administered for relief of moderate anxiety in 20 anginal patients seen in office practice over a 20-week period. Symptoms of emotional distress related to anxiety were rated at base-line, one week, two weeks and monthly thereafter. Relief was obtained notably early in therapy. The clinical results demonstrated that Librium offers the coronary patient an antianxiety drug that, in the author's opinion, is both effective and safe. In general use, the most common side effects reported have been drowsiness, ataxia and confusion, particularly in the elderly and debilitated. (See summary of prescribing information.)

Librium (chlordiazepoxide HCl) is used concomitantly with certain specific medications of other classes of drugs, such as cardiac glycosides, diuretics and antihypertensive agents, whenever anxiety is clinically significant. The drug should be discontinued after anxiety has been reduced to appropriate levels.

The positive power of adjunctive Librium® (chlordiazepoxide HCl)

10-mg, 25-mg capsules up to 100 mg daily

for moderate to severe anxiety accompanying angina pectoris

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Indicated when anxiety, tension and apprehension are significant components of the clinical profile.

Contraindications: Patients with known hypersensitivity to the drug.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. As with all CNS-acting drugs, caution patients against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported. Use of any drug in pregnancy, lactation, or in women of childbearing age requires that its potential benefits be weighed against its possible hazards.

Precautions: In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (*e.g.*, excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

Adverse Reactions: Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.

Supplied: Librium® Capsules containing 5 mg, 10 mg or 25 mg chlordiazepoxide HCl. Libritabs® Tablets containing 5 mg, 10 mg or 25 mg chlordiazepoxide.

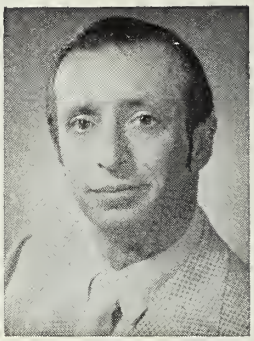
*Levine, S.: "Angina Pectoris and Emotional Overlay," Scientific Exhibit presented at the Annual Meeting of the Maine Medical Association, Kennebunkport, Me., June 13-15, 1971.

A copy of the Levine study may be obtained from your Roche representative.

ROCHE

Roche Laboratories
Division of Hoffmann-La Roche Inc.
Nutley, N.J. 07110

the presidents page



An Aggressive Response

Once again ISMS has become the aggressor in a fight for your rights. The action . . . persuading the Aetna Life and Casualty Company to stop sending its controversial "cost of defense" letters.

Aetna's letter offered assistance to patients involved in legal disputes with physicians who were trying to recover fees that exceeded the company's fee profiles. Aetna inferred that charges above these profiles—which were constructed without consulting medicine at any level—were "unreasonable."

ISMS met with representatives of Aetna on May 5—just a few short weeks after the first letters were sent. Aetna AGREED to "cease and desist" and to submit future fee disputes to peer review. . . . But while most letters stopped, some were still being sent from various Aetna branch offices in mid June.

Therefore, at their July meeting, the ISMS Board of Trustees expressed objection to companies offering "hold harmless" benefits and moved to send an explanation of its position to other state medical societies and the AMA Council on Medical Services.

The Board also approved the "Statement of Understanding" contract. This contract—for use by physicians prior to treating patients covered by such policies—points out that the patient is solely responsible for a physician's fees.

A doctor-patient contract may not be the ultimate answer, but when faced with paying medical costs supposedly covered by his policy, the patient may realize the myth of "full coverage" insurance and demand something be changed.

And it's time we—as individual physicians—DEMAND that third party carriers who boast of "full coverage" give we physicians a voice in constructing "usual and customary" fee profiles.

But all the hard-hitting action by ISMS will be ineffective without the STRONG support of we physicians. We MUST give our patients the facts about the so called "full coverage" policies of some carriers. . . . And we MUST support the action of the Board of Trustees.

The battle waged by ISMS in this instance is typical of the society's efforts on your behalf. If you think you have an inactive, unresponsive state society, read "ACTION REPORT" and see just what is being accomplished. If you aren't receiving ACTION REPORT, our semi-monthly newsletter, write to ISMS and have your name added to the mailing list.

I assure you, your state society IS leading the fight. But ISMS needs the support of ALL physicians.

Frank J. Jirka Jr. M.D.

...NO TRANQUILIZER CAN DO THAT!

Emotional symptoms, such as anxiety, depression, nervousness, and fatigue, may be related to a diminishing production of estrogen. In such cases, PREMARIN, by providing specific replacement of estrogen, can help relieve much of the emotional distress of the menopause...in addition to the classic symptoms of hot flushes and sweats.

Sedatives, tranquilizers, and psychotherapy, of course, may be helpful in some selected cases, but they cannot correct the underlying vasomotor and metabolic disturbances, nor the nonspecific emotional component related to loss of hormonal support.[1-4]

Many psychosomatic symptoms which occur at this time of life appear to correlate fairly well with declining estrogen levels.[2-5] And in patients where emotional instability has been latent, such manifestations may be unmasked and even magnified.[4]

Anxiety and depression resulting from estrogen deficiency usually respond to estrogen therapy in a relatively short time.[2] Other "psychogenic" symptoms such as headaches, crying spells, insomnia, feelings of weakness and fatigue due to estrogen deficiency may also be relieved.[1,3,5] And in the large majority of patients, PREMARIN imparts a renewed sense of well being.[6]

When your menopausal patient suffers emotional distress resulting from estrogen deficiency, PREMARIN can often help—because it gives her back some of the estrogen support she's lost.

BRIEF SUMMARY. *(For full prescribing information, see package circular.)*
PREMARIN® (Conjugated Estrogens Tablets, U.S.P.)
Indications: PREMARIN provides specific replacement therapy in the management of estrogen deficiency states, notably in the menopause and postmenopause.
Precautions: *In the female:* To avoid continuous stimulation of breast and uterus, cyclic therapy is recommended (3 week regimen with 1 week rest period—Withdrawal bleeding may occur during this 1 week rest period).
Failure to control breakthrough bleeding or unexpected recurrence is an indication for curettage.
In the male: Continuous therapy over prolonged periods of time may produce gynecomastia, loss of libido, and testicular atrophy.
Dosage and Administration: Cyclic administration is recommended (3 weeks of daily estrogen therapy and 1 week off).
If patient has not menstruated within last two months or more, cyclic administration is started arbitrarily. If patient is menstruating, cyclic administration is started on day 5 of bleeding.
If breakthrough bleeding occurs (bleeding or spotting during estrogen therapy), increase estrogen dosage as needed to stop bleeding. In the following cycle, the dosage level which was employed for hemostasis should be used for daily administration. In subsequent cycles, the estrogen dosage is gradually reduced to the lowest level which will maintain the patient symptom-free. (See Precautions.)
Menopause (natural or artificial)—PREMARIN 1.25 mg. daily, cyclically. Adjust dosage upward or downward according to severity of symptoms and response of the patient. For maintenance, adjust dosage to lowest level that will provide effective control. Many clinicians favor continuing cyclic estrogen replacement therapy throughout the postmenopause as a protective influence against accelerated degenerative changes at the cellular level.
Postmenopause—(If uterus is intact the patient is considered postmenopausal from one year after cessation of menstruation to end of life span.) If the presenting symptoms are those of the menopause, see above for dosage. As a protective measure against premature degenerative changes in bone and cellular metabolism (*e.g.* atrophic vaginitis, osteoporosis), give PREMARIN daily and cyclically. Adjust dosage to lowest effective but subbleeding level.
Estrogen Deficient Atrophic Vaginitis, Kraurosis Vulvae, and Pruritus Vulvae—1.25 mg. to 3.75 mg. daily, or more, cyclically—depending on the tissue response of the individual patient.
How Supplied: PREMARIN (Conjugated Estrogens Tablets, U.S.P.). No. 865—Each *purple* tablet contains 2.5 mg. No. 866—Each *yellow* tablet contains 1.25 mg. No. 867—Each *red* tablet contains 0.625 mg. No. 868—Each *green* tablet contains 0.3 mg.
Bottles of 100 and 1,000. The 1.25 mg. potency also available in unit dose package of 100.

References: 1. Kupperman, H.S.: Medical Aspects of Human Sexuality *1*:64 (Sept.) 1967. 2. Rhoades, F.P.: J. Amer. Geriat. Soc. *15*:346 (Apr.) 1967. 3. Kerr, M.D.: Mod. Treatm. 5:587 (May) 1968. 4. Greenblatt, R.B., in Conn, H.F. (Ed.): Current Therapy 1970. Philadelphia, W.B. Saunders Company, 1970, p. 757. 5. Astwood, E.B., in Goodman, L.S., and Gilman, A. (Eds.): The Pharmacological Basis of Therapeutics, ed. 4, New York, The Macmillan Company, 1970, Chap. 69 p. 1538. 6. Tramont, C.B.: Geriatrics *21*:212 (Nov.) 1966.

7148 Ayerst® AYERST LABORATORIES, New York, N.Y. 10017

PREMARIN® BRAND OF
CONJUGATED ESTROGENS TABLETS, U.S.P.
containing natural estrogens exclusively



new pharmaceutical specialties

by paul dehaen

For detailed information regarding indications, dosage, contraindications and adverse reactions; refer to the manufacturer's package insert or brochure.

Single Chemicals—Drugs not previously known, including new salts.

Duplicate Single Products—Drugs marketed by more than one manufacturer.

Combination Products—Drugs consisting of two or more active ingredients.

New Dosage Forms—Of a previously introduced product.

The following new drugs have been marketed:

SINGLE CHEMICALS

BILOPAQUE Diagnostic-Contrast Media ℞
Manufacturer: Winthrop
Nonproprietary Name: Tyropanoate sodium
Indications: Cholecystography
Contraindications: Advanced hepatorenal disease, severe impairment of renal function, severe G.I. diseases that prevent absorption.
Warnings: Safety for use during pregnancy has not been established. Use in children under 12 not recommended.
Dosage: 3 gms., single dose.
Supplied: Capsules, 750 mg.

MEGACE Progesterone ℞
Manufacturer: Mead Johnson
Nonproprietary Name: Megestrol acetate
Indications: Adjunctive therapy in recurrent or metastatic endometrial carcinoma.
Precautions: Pts. with history of thrombophlebitis
Dosage: 40 mg./day in divided doses
Supplied: Tablet, 20 mg.

DUPLICATE SINGLE PRODUCTS

ALBUTEIN Hospital Solution ℞
Manufacturer: Abbott
Nonproprietary Name: Normal serum albumin (human) 25% solution (salt poor)
Indications: Shock, burns, hypoproteinemia, acute pancreatitis, prevention and therapy of cerebral edema.
Contraindications: Severe anemia or cardiac failure.
Dosage: Variable
Supplied: Vial, 50 and 100 cc.

GAMULIN Rh Biological ℞
Manufacturer: Dow
Nonproprietary Name: Rho (D) Immune Globulin (Human)
Indications: To suppress immune response of nonsensitized Rho (D) neg. mothers following Rh incompatible pregnancies.
Contraindications: To be given to the postpartum mother only, not to the infant.
Supplied: Vial

PLASMATEIN Hospital Solution ℞
Manufacturer: Abbott
Nonproprietary Name: Plasma protein fraction (human) 5% solution
Indications: Shock, burns, hypoproteinemia
Contraindications: Severe anemia or cardiac failure.
Dosage: Variable
Supplied: Vial, 250 and 500 cc.

SORQUAD Vasodilators coronary ℞
Manufacturer: Tutag
Nonproprietary Name: Isosorbide dinitrate
Indications: Prophylaxis and treatment of angina.
Contraindications: Hypersensitivity
Precautions: Glaucoma
Dosage: Adjust to response; usual: 5-10 mg. 3 or 4 times/day.
Supplied: Tablets, 5 mg. and 10 mg.

COMBINATION PRODUCTS

CYSTOSPAZ-SR Muscle Relaxants-General ℞
Manufacturer: Conal
Composition: Each capsule contains:
Butabarbital 45 mg.
1-Hyoscyamine Sulfate 375 mcg.
Indications: Adjunctive management of smooth muscle spasm.
Contraindications: Acute glaucoma, pyloric stenosis, and hypersensitivity to belladonna alkaloids or barbiturates.
Precautions: Elderly pts., incipient glaucoma, hepatic or renal disease, or urethral obstruction particularly prostatic hypertrophy.
Dosage: 1 capsule, twice daily
Supplied: Capsules

NEW DOSAGE FORMS

MINTEZOL Anthelmintics ℞
Manufacturer: Merck, Sharpe & Dohme
Nonproprietary Name: Thiabendazole
Indications: Susceptible parasitic infections.
Contraindications: Hypersensitivity
Warnings: Activities requiring mental alertness should be avoided. Safety for use during pregnancy has not been established.
Precautions: Hepatic and renal dysfunction pts. should be carefully monitored.
Dosage: Pts. less than 150 lbs.: 20 mg./lb./day
Pts. more than 150 lbs.: 3.0 gm./day
Supplied: Chewable tablets, 500 mg.

NILSTAT Fungicides-Topical ℞
Manufacturer: Lederle
Nonproprietary Name: Nystatin
Indications: Treatment of cutaneous or mucocutaneous monilial infections.
Contraindications: Hypersensitivity
Dosage: Apply liberally to affected areas twice daily
Supplied: Cream, 100,000 U./gm. Tube, 15 gm.

IMJ
Illinois Medical Journal
Vol. 142, No. 2, August, 1972

Air Controllers Syndrome

Peptic Ulcer In Air Traffic Controllers

By Richard R. Grayson, M.D./St. Charles

During a serious labor-management dispute between the Federal Aviation Administration and its employees, the air traffic controllers, in March, 1970, many of the controllers simultaneously ceased their work in a "sick-out" and reported to private physicians for evaluation of chronic stress-related symptomatology. I examined and treated 111 air traffic controllers during a one-year period beginning with the onset of the "sick-out."

Eighty-six of these men exhibited signs and symptoms of peptic ulcer sufficiently severe that they were referred to local hospital radiologists for upper gastrointestinal evaluations by means of barium meal examination. Sixty-six of these examinations were reported as pathological. Thirty-six men had X-ray evidence of peptic ulcer.

Results

Of the group of 111 controllers, 86 men were given the standard upper gastrointestinal X-ray studies. Nine categories of radiological findings were identified. These categories and the criteria are (See Table 1):

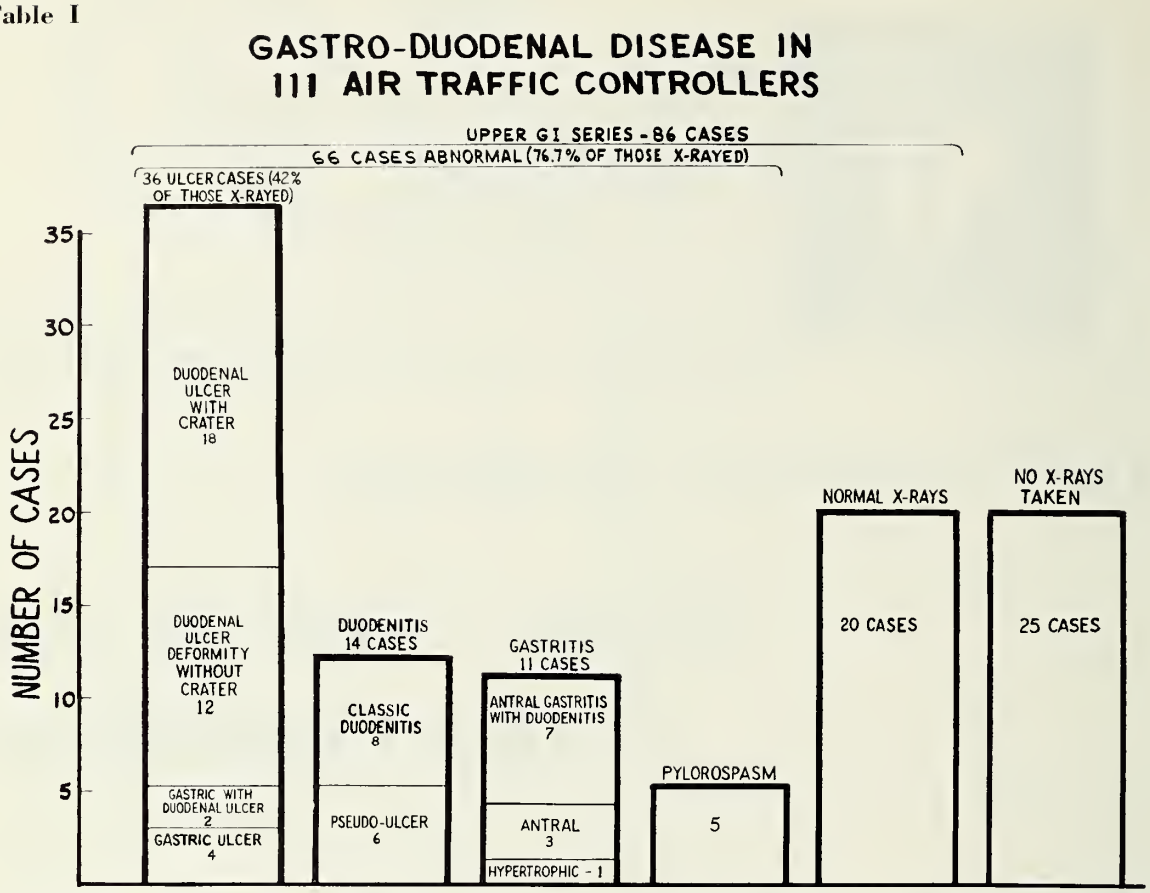
1. *Duodenal ulcer with crater:* There were 18 cases in which a crater, a niche, or an ulceration of the duodenal bulb or of the post-bulbar duodenum were reported, with or without signs of duodenitis.

2. *Duodenal ulcer deformity without crater:* Twelve were found in which there was a persistent deformity or irregularity, slight or marked, of the duodenal bulb, with or without signs of duodenitis, or of the post-bulbar duodenum.

3. *Duodenitis:* a) Eight cases of typical duodenitis and b) Six cases of atypical duodenitis ("pseudo-ulcer") were found. These 14 cases are listed together under the heading of duodenitis. Radiographically, typical (classic) duodenitis was considered present when prominent or coarsened mucosal folds in the duodenal bulb were demonstrable and were associated with bulbar spasm and/or irritability.

Six cases in which bulbar spasm, irritability, and usually pylorospasm were seen radiographically, but in which there was no mucosal ab-

Table I



normality detected were classed as atypical duodenitis. Such patients, who complain of epigastric distress simulating the classic features of peptic ulcer, are commonly labeled "pseudo-ulcer." Causes of the pseudo-ulcer syndrome include: a) Non-visualized superficial ulcer and b) Duodenitis.

A clinical, radiological, and statistical study[1] showed that peptic ulcer developed in about 40% of cases originally diagnosed pseudo-ulcer, but that "reasons exist for not regarding pseudo-ulcer a true precursor of peptic ulcer."

4. *Gastric ulcer with crater:* Four cases included:

a. Ulcer in the pyloric canal (channel ulcer),
b. Prepyloric ulcer,
c. Distal antral ulcer.

5. *Gastric ulcer and duodenal ulcer combined:* Two cases were found of double ulcers, increasing the total of ulcers in the series to 38 while the number of men with ulcers was 36. There was thus a cumulative total of 32 duodenal ulcers and six gastric ulcers.

6. *Hypertrophic gastritis, chronic:* One case was found. Enlarged rugae were present radiographically throughout the stomach without evidence of ulceration.

7. *Antral gastritis:* 10 cases. Seven of these patients also demonstrated duodenitis and are different patients from those listed under the heading of duodenitis. Three patients had antral gastritis by X-ray without any other demonstrable gastroduodenal pathology. Originally one other case of antral gastritis was diagnosed, but this patient later developed a demonstrable duodenal ulcer and is included under that heading. Antral gastritis in this series is defined as any combination of the following radiographic signs:

a. Persistent deformity or rigidity of the antrum.
b. Irregularity, coarsening, or prominence of

RICHARD R. GRAYSON, M.D., is in the private practice of internal medicine in St. Charles. A graduate of the University of Illinois College of Medicine, he is on staff at Delnor Hospital, St. Charles, and Community Hospital, Geneva. Dr. Grayson is a member of the Academy of Air Traffic Control Medicine, which he serves as president. He has done research in the field of stress disease and has published on this topic.

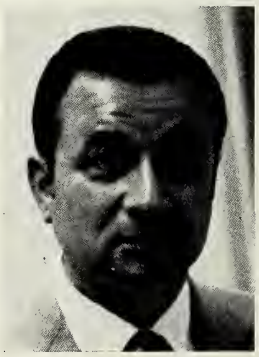
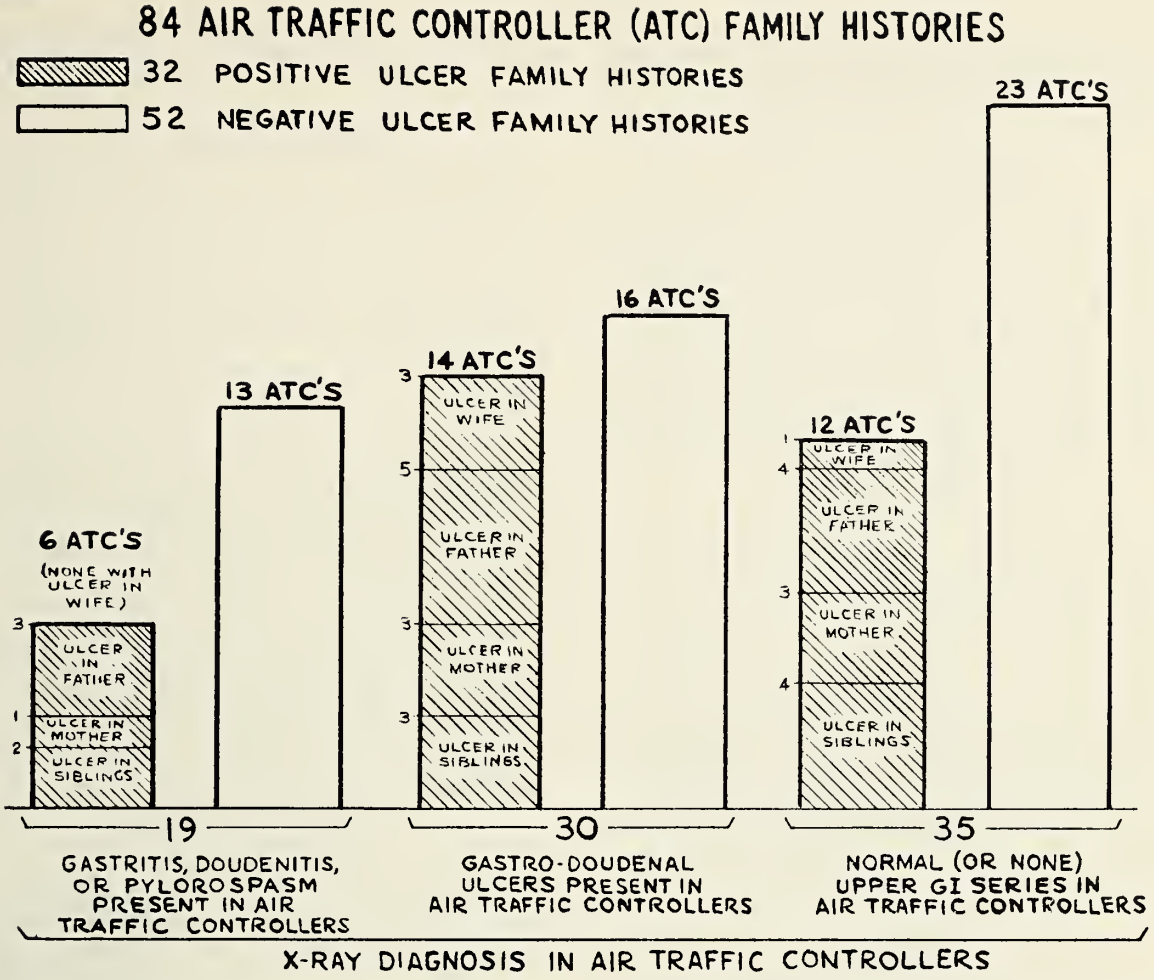


Table II



the antral or prepyloric mucosal pattern.

c. Protrusion of the antral mucosa into the duodenal bulbar base. (This sign was found in combination with others in all cases and therefore was not considered a sign of gastritis alone.)

d. Irritability and spasm of the antrum, prepylorus, and/or pylorus,

8. *Pylorospasm:* Six cases exhibited delayed gastric emptying in the presence of normal or increased gastric peristalsis. No other pathology was discovered. In one of these a follow-up radiologic examination two months later revealed a duodenal ulcer crater. The final total for the series, therefore, is five cases of pylorospasm.

9. *Normal upper G.I. series:* No abnormalities of contour or function were reported in 20 of the 86 cases examined radiographically.

Family History

In the present series of 111 air traffic controllers, there was family information concerning ulcer incidence in 84 (Table II). Of 30 air traffic controllers with proven gastroduodenal ulcers, 14 had positive ulcer family histories, whereas, of 35 controllers with no ulcers, 12 had positive family histories.

Appraisal of the family history data raises interesting questions for a larger, statistically significant study of air traffic controllers; there were 84 men whose family history was known and, of these, there were 12 men whose fathers had ulcers by history. Eight of the twelve ulcer-prone fathers were from the 49 ulcer-prone controllers. However, there were only four ulcer-prone fathers among the 35 controllers who had normal upper G.I. X-rays.

There were four ulcer-prone mothers in the first group and three ulcer-prone mothers in the normal group, an even distribution.

The ulcer-prone siblings also were divided equally between the abnormal and the normal controllers; there were five ulcer-prone siblings among the 49 ulcer-prone controllers, and four ulcer-siblings among the 35 normal controllers.

Statistical analysis with such small groups of people probably is not useful. However, the finding of more fathers and wives with a history

of ulcer among the ulcer-prone controllers than in their ulcer-free brethren is a coincidence that in itself may point to a relationship.

Smoking and Ulcers

Because positive correlation has been shown between the occurrence of peptic ulcers and smoking cigarettes[2] the responses of 70 controllers concerning smoking were analyzed. When non-smokers and smokers were compared to men categorized as to normal and abnormal upper gastrointestinal X-ray series, an interesting difference appeared which seems to implicate smoking as a positive factor in peptic ulcer occurrence.

Table III

	Normal GI series	Abnormal	Total
Non-smokers (cigarettes)	15	20	35
Smokers	5	30	35
Total	20	50	70

Peptic Ulcer Incidence in Other Groups

The proven incidence of peptic ulcer in the present group of air traffic controllers is 32.5%. A search of extant medical publications has not revealed any other group with so high an incidence of peptic ulcer.

Physicians

As estimated by a mail questionnaire to which 8,052 (92%) of 8,716 eligible physicians responded, 11% of male Massachusetts physicians above the age of 45 reportedly have had a duodenal ulcer. The estimated annual incidence in males was between 2.5 and 4.0 per 1,000 in all age groups above the age of 25. About 1.5% of male physicians over 45 have had a gastric ulcer. These results did not indicate that peptic ulcer was unduly frequent among male physicians.[3]

Alcoholics

The prevalence of peptic ulcer was studied in 922 employees known to be problem drinkers in a large American company with a total employee population of 100,000. Of the drinkers, 20 or 3% were known to have gastric ulcer and 74 (8%) had duodenal ulcers. The history of ulcers was twice as great among drinkers as among a group of matched controls.[4]

Under Stress

A review of stress ulcers showed that the incidence of acute ulcers of the upper gastrointestinal tract in consecutive autopsies ranged from 1 to 6%.[5]

Coronary Patients

In a prospective study on coronary heart disease among 3,524 men aged 39 to 59 reported after two years of study, the incidence of peptic ulcer in the entire group was 9%. Among 70 cases of coronary heart disease discovered during this time, the incidence of peptic ulcer was 12.9%.[6]

Clerks

In a disability claim study of diseases during the period of 1963 to 1964 in Metropolitan Life Insurance Company clerical personnel, the annual incidence of gastroduodenal ulcer and gastritis among men aged 25 to 44 was 4.4 per 1,000 male personnel. The average disability per case in this same group was 28 days. There were 30,000 male employees in all, from which number there occurred 6,200 disability claims. Eighteen percent of the total claims were for digestive diseases. This was the leading cause of disability among the male employees.[7]

Airline Stewards

An analysis was made of the morbidity from peptic ulcer among airline stewards over a nine-year period. The mean annual population was 1,313 and the overall incidence was 2.6 per 1,000 per year. When corrected for age, the morbidity was very similar to that found among civilian airline pilots in a short-haul airline. The morbidity did not show any features which could be attributed to occupation or working conditions.[8]

Rural Workers

A three-year survey among 1,500 males in a semi-rural population revealed a prevalence rate for demonstrable peptic ulcer of 102 per thousand. A new rate expressing peptic ulcers per thousand dyspeptics (in this survey, 305 per 1,000) was described.[9]

Lawyers

A study of 2,342 questionnaires returned by Cleveland attorneys indicated an incidence of "stomach ulcer" ranging from 7.1% to 11.3%.[10]

Morbidity

According to the National Health Survey of the National Center for Health Statistics[11], peptic ulcer is one of the leading chronic conditions

causing disability. From 1963 through 1965 the average number of persons in the United States with some limitation of activity due to peptic ulcer was 550,000. Of these, 114,000 persons were unable to carry on a major activity due to peptic ulcer.

Discussion

If peptic ulcer is a disease caused by stress, as it appears to be, then the stress of the occupation of air traffic controller as it is presently constituted possibly is the cause of the unprecedented high incidence of peptic disease in the series here reported. When the manifold stresses in the lives of these men are considered, the nucleus of the stress constellation is the mid-air collision. All roads lead to Rome; every occupational stress found leads to the increased possibility of a mid-air collision. A narrowly averted mid-air collision caused by one of these conscientious, intelligent, punctilious young men has the same effect on him as if he himself had just escaped death by a hair's breadth. The "fight or flight" response that follows is useless because he is trapped at a radarscope, forced to continue issuing cool, concise commands into a microphone. The symptoms that follow, such as anxiety, anorexia, insomnia, and irritability, plus their spin-off effects of marital discord, interpersonal animosities, and efforts at peer-group support all then become stressors in their own right.

This constellation of stresses surrounding the central fact of the mid-air collision and the near-miss is the shadowy monster in the nightmare. When in the future the central problem is resolved, and the individual controller is no longer trapped alone in his daily drama, then the other stresses, and the ulcers, will return to more customary dimensions.

The medical issue of peptic ulcer in this series has economic, political, and sociologic ramifications. The present epidemic of peptic ulcer was at once both a symptom of a labor-management problem, and also a cause of an escalation of that problem. The stresses not only had reached a level which resulted in chronic incapacitating illness in significant numbers of men who were still attempting to function in their jobs, but also had finally reached the stage where many of these men allowed themselves the luxury of indulging their survival instincts. In other words if the stress of potential mid-air collisions or near-misses excites the fight or flight response, then it is natural one day for the individual to do just that: either fight (demand less stressful working conditions) or flee (leave the job).

When the "sick-out" of the air traffic controllers is viewed in the clinical context described above, rather than in the pejorative context of the usual labor dispute, a case can be made for a real medical appraisal of the problem. The etiology of ulcer was the same as that of the sick-out: the increasing danger of mid-air collisions as air traffic density increased and controller staffing diminished. As the dangers increased, the stress increased. Peptic ulcers were a manifestation of a problem that was primarily a systems problem. The system of air traffic control had fallen behind the needs of the men operating it.

Summary and Conclusions

1. In the present series, 32.5% of the employees evaluated by the author suffered from duodenal and gastric ulcers which had previously, in most cases, been undiagnosed and untreated.

2. Peptic ulcer in this series is concluded to be a stress-related disease, the stress being occupational. Possibly the most significant recurring stress is the crisis that occurs when an air traffic controller is involved in a narrowly averted mid-air collision of commercial aircraft under his control.

3. It is important to identify stresses in ulcer patients so that intelligent medical management may be instituted. Prevention of ulcer recurrence in this occupational group has far-reaching implications to the safety of the flying public, to the proper functioning of the air traffic control system, and to the economy of the country.

4. Most of these patients initially complained of anxiety states, generally referred to as "nervousness" or a "nervous stomach." It is suggested that all air traffic controllers who complain of anxiety states, nervous stomachs, or chronic diarrhea be evaluated closely for peptic ulcer, gastritis, or duodenitis.

5. There were more ulcer-prone fathers and wives among the group of patients who demonstrated abnormal gastroduodenal X-rays. The significance of this relationship is not known.

6. Smoking cigarettes and cigars was a positive factor in the group with the abnormal gastroduodenal X-ray findings. A causal relationship was not established. ◄

References

1. Krag, E.: "Pseudo-ulcer and True Peptic Ulcer," *Scandinav the Danish Medical Bulletin* 178: 713-728 (Dec. 1965).
2. Monson, R. R.: "Familial Factors in Peptic Ulcer," *Amer J Epide*, Vol. 91, No. 5, May 1970.

(Continued on page 152)

The Relationship of Degenerativ

By Sol K. Robinson, M.D./Michigan City, Ind.

A Survey

In this study, fifteen degenerative diseases such as stroke, obesity, thyrotoxicosis, coronary artery disease (CAD), diabetes, etc., and frequently encountered symptom-complexes such as dyspnea, headache, dizziness and nervous tension were arranged according to the height of the blood pressure (BP). All persons with the same clinical diagnosis were put in one group and the BP averaged. When this was done, a BP differential was found between some of these diseases which may have some clinical value in a preventive program for CAD and Hypertension (HY).

There were 666 white persons in the survey and all blood pressures were taken by one examiner. To get a fair cross country sampling the subjects were obtained from four medium sized cities, one in the east, one in the midwest and two in the south. In obtaining the participants a volunteer system was avoided, the survey was unannounced. Representative areas were designated in each city, all houses in that area canvassed and all family members asked to participate. In this way persons of different ages were obtained. Response was good, about 85% co-operated. There was no selection, they were from all walks of life. There were housewives, skilled and unskilled workmen, students, teachers, shop keepers etc.

A medical and family history relating to present and past ailments, kind of work, dietary habits, temperament and mental attitudes was obtained. Since a prospective study takes much time and is very expensive, it was decided to make use of a previous clinical diagnosis. This was found to be sufficiently reliable. Dunn and associates, also Sobje made use of it.[1,2] Three to eight BP readings were made on each participant and the average used. This avoids some errors and gives a 'near basal' BP. Diastolic BP was recorded at the first muffling of the fourth phase.

In a study of this kind there are several sources of error, the BP varies, and there may be a change, if the BP is taken at another time. Sobje investigated this and concluded that it was not of sufficient magnitude to invalidate the results. There is also the factor of age variance, since some diseases occur in younger people than others. A correction was made for this and all 15 disease groups were brought to the same approximate age distribution as for the total 666 persons in the survey. Since the BP falls after a myocardial infarct, the BP prior to the infarct was obtained.

Terms and Criteria

CORONARY ARTERY DISEASE: A clinical diagnosis or ECG evidence of myocardial infarction or impairment of the coronary vessels. Angina pectoris was included.

MEAN ARTERIAL PRESSURE: Diastolic pressure plus one third the pulse pressure. This is a more accurate way of expressing the BP, since it combines both pressures.

HEADACHE: Included migraine and other forms of persistent headache.

FATIGUE: A marked lack of energy or marked weakness.

HYPERTENSION is one of the degenerative diseases, but was not included in this study since the BP was used as the basis of comparison. In addition, evidence herein suggests that the value of 160/95 mm Hg set for HY by the World Health Organization is much too high and would give misleading information.

Results

Diseases and symptom-complexes were classified into two groups—uncomplicated when the disease existed alone—complicated when the disease was the dominant one and complicated by one or more of the others. Arrangement in the table was according to the height of the MAP and it shows a BP differential for cardiac hypertrophy, stroke and CAD-123.2, 116, and 110.4 mm Hg respectively for the MAP. This differential has clinical significance as we shall show and it is hoped that others will make similar surveys to confirm it. Altogether the degen-

Diseases To The Blood Pressure

The Relationship of the Degenerative Diseases & Symptom-Complexes to the Blood Pressure

COMPLICATED

Name	No.	Systolic Blood Pressure mm Hg	Diastolic Blood Pressure mm Hg	Mean Arterial Pressure mm Hg
Cardiac Hypertrophy	12	169.1	100.3	123.2
Obesity	115	164.4	100.8	122
Headache	24	159.8	101.9	121.2
Dyspnea	22	161	99	119.7
Coronary Artery Disease	28	154.1	96.6	115.7
Stroke	15	154.3	95.4	115
Diabetes	23	156.3	93.3	114.3
Dizziness	20	146.7	92.6	110.6
Nervous Tension	114	136	90.7	105.8
Thyro-toxicosis	20	139.3	89	105.8
Colitis	10	140	87.9	105.3
Asthma	16	138.3	88.7	105.2
Arthritis	21	135.6	86.7	103
Fatigue	12	131.7	85.9	101.2
Peptic Ulcer	18	130	82.7	98.5

UNCOMPLICATED

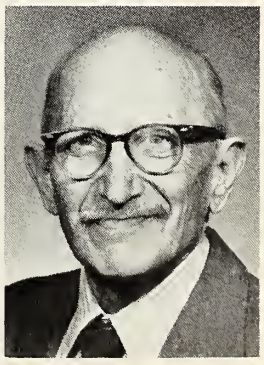
Name	No.	Systolic Blood Pressure mm Hg	Diastolic Blood Pressure mm Hg	Mean Arterial Pressure mm Hg
Headache	10	160.9	103.6	122.7
Stroke	9	164.3	92.5	116.4
Diabetes	10	160.9	94.2	116.4
Obesity	65	153.9	96.5	115.6
Nervous Tension	54	146.3	93.5	111.1
Coronary Artery Disease	16	147.3	92	110.4
Thyro-toxicosis	12	132.4	86.9	102.1
Dyspnea	9	132.1	86.2	101.5
Asthma	8	132.1	84.4	100.3
Dizziness	9	135.6	82.7	100.3
Arthritis	12	132.1	81.5	98.4
Colitis	7	130	81.8	97.9
Fatigue	9	120.8	79.4	93.2
Peptic Ulcer	11	119.2	76.6	90.8

erative diseases covered a range from 90.8 to 122.7 mm Hg for the MAP and from 76.6 to 103.6 mm Hg for the diastolic pressure.

Comparisons in the uncomplicated columns in the table are more accurate since the diseases were present alone. All instances but one of cardiac hypertrophy, which included also congestive failure, were complicated. However, for comparison, cardiac hypertrophy is considered to be in the uncomplicated column as well. Since the complications are with other diseases that carry a lower BP, it might be even higher if uncomplicated and the differential between it and CAD might be even wider. The differential between cardiac hypertrophy and CAD is seen in the complicated column too, but CAD and stroke reverse their positions. This is probably an artifact due to the averaging as aforementioned. Peptic ulcer demonstrates this; since all the others have higher BPs, peptic ulcer becomes higher on averaging.

Depending on the height of the MAP the degenerative diseases were again divided into groups, vascular and non-vascular. Those with a MAP above 106 mm Hg, or when the figures on both sides of the table averaged this were put in the vascular group, those below this figure in the non-vascular group. A MAP of 106 mm Hg was chosen, because it is slightly above the average for all participants in the survey. If we used a diastolic BP of 90 mm HG to make the division the result would be the same. Cardiac hypertrophy, obesity, dyspnea, headache, stroke, diabetes, CAD and nervous tension made up the vascular group. They were also heavily complicated with each other, which is additional evidence that they may be related. The non-

SOL K. ROBINSON, M.D., practices internal medicine. He specializes in hypertension and cardiology. He received his M.D. at the University of Chicago, Rush Medical Center and his internship at the St. Louis City Hospital.



vascular group consisted of asthma, colitis, arthritis, fatigue and peptic ulcer. They had lower BPs and were not so frequently complicated with the vascular group. Thyrotoxicosis and dizziness were in a borderline position, but there is previous evidence showing a relation between thyrotoxicosis and HY[3]. Dizziness leans to the vascular group.

Comment

All in the vascular group except headache and dyspnea are now considered risk factors in CAD. In this survey the relation between headache and HY was quite strong, but a recent report failed to show a relation.[4] Dyspnea was heavily complicated with the cardiac diseases and in several instances the BP was sharply elevated. Recent evidence shows that the presence of dyspnea was the best single predictor of death in coronary heart disease.[5] It would appear that dyspnea should be considered a risk factor in HY and CAD, but this needs confirmation.

Several instances of CAD were seen with only moderately elevated BP, with diastolic HY, or even with normotension. This was also true in some instances of cardiac hypertrophy and stroke. In such cases where the BP was normal the risk rose with age. Of 28 instances of CAD, 10 had a diastolic BP below 90 mm Hg. The effect of the level of BP on CAD morbidity was again demonstrated in the treatment of hypertensives by the Veterans group.[6] Whereas congestive heart failure and stroke were benefited, CAD was not. Hood and associates got similar results.[7] Another study showed benefit in renal failure and stroke, while deaths from myocardial infarction increased.[8] This is a limiting factor in our present drug treatment for HY. We are saving men from heart failure and stroke, but many still die of CAD, and this can hardly be explained by increased longevity.

The average initial diastolic pressure in the Veterans group was 104.7 mm Hg. Despite the fact that this was reduced by an average of 17.4 mm with drugs, the resulting BP was probably still high enough in some to cause CAD. This explanation is suggested by the aforementioned finding in this survey, that there is a BP differential between cardiac hypertrophy, stroke and CAD. This may be too simple an explanation for a complex disease; hyperlipidemia, smoking, and nationality are also important. However, in white American males, it appears that the heart is susceptible to even moderately elevated BPs.

There is evidence from the Actuaries that CAD may be mediated by only moderately elevated BP. For the ages 40 to 49 with a diastolic pressure of 84-88 mm Hg, a moderate systolic rise from 135 to 153 mm Hg resulted in a 90 per cent rise in mortality.[9,10] At this age about 45% of the deaths are due to CAD. Metropolitan Life Insurance figures for young adults show for 140/95 mm Hg a mortality rise 2.5 times over standard risk.[11] This strongly suggests that moderately elevated BP contributes to CAD.

Stamler[12] has also shown that coronary disease is rather common down to 80 mm Hg diastolic and frequently occurs at BPs commonly regarded as normal. The rate per thousand for clinical coronary disease in men ages 40 to 59 at various diastolic levels was as follows: below 80 mm Hg, 19; 80 to 89 mm, 41; 90 to 94 mm, 46; over 95 mm, 82. Note the sharp rise at 80 mm Hg diastolic, also that more than half occurred below a diastolic pressure of 95 mm Hg. The possibility of an incubation period for CAD at these lower levels of BP should be investigated; the attack may not be as sudden as it appears.

Some of the damage resulting from HY appears to be reversible. That papilledema can be resolved, cardiac hypertrophy decreased, renal deterioration arrested and partly reversed have been several times reported.[13,14] From the evidence presented, it would seem that CAD might also be benefited if the poor risk patient is identified earlier and the diastolic BP held between 80 to 85 mm Hg. Yet reducing the BP with hypotensive drugs to such low levels has been disappointing in lowering CAD mortality.[7,8] Moreover there is evidence that the hypotensive drugs may even be contributing to CAD mortality.[8,15]

According to a recent poll, physicians rely too much on hypotensive drugs and the fall in BP, even in mild HY.[16] Instead it might be better to look for measures that benefit CAD, the chief cause of death in mild HY. Advisable, particularly in mild HY, is a regimen based on reassurance, a modified-fat and salt poor diet, daily exercise, no smoking, and avoiding anxiety and stressful occupations.[17,18,19] Mild HY differs from the severe form in several ways; a report on it and how it may be identified is now in preparation. Such a regimen holds much promise, but the physician must become convinced of this. If he is not, he cannot convince others to make the sacrifices to insure a successful preventive program. The outlook is grim; one male in five is threatened with a heart attack; we cannot afford to wait for all the evidence to come in.

Summary

In a survey of 666 persons, 15 degenerative diseases and symptom-complexes were arranged according to the height of the mean arterial pressure (MAP). They covered a range from 90.8

to 122.7 mm Hg for the MAP and from 76.6 to 103.6 mm Hg for the diastolic pressure. These diseases were divided into two groups, a vascular group made up of cardiac hypertrophy, obesity, headache, stroke, diabetes, coronary artery disease, dyspnea and nervous tension, and a non-vascular group made up of asthma, arthritis, colitis, fatigue and peptic ulcer. The vascular group had a higher average BP than the non-vascular and were frequently complicated with each other. A blood pressure differential was observed between cardiac hypertrophy, stroke and coronary artery disease, with values of 123.2, 116 and 110.4 mm Hg respectively for the MAP. Its significance in a primary prevention program is discussed. ◄

References

1. Dunn, J. P., Ipsen, J., Elsom K. O., et al: Risk factors in coronary artery disease, hypertension and diabetes. *Am. J. Med. Sci.* 259:309-322, 1970.
2. Sobje, P.: Heredity in essential hypertension and nephrosclerosis. Copenhagen, Arnold Busck, 1948.
3. Robinson, S. K.: The age distribution and sex incidence of hyperthyroidism and hypertension. *Endocrinol* 26:409-417, 1940.
4. Waters, W. E.: Headache and blood pressure in the community. *Brit. Med. J.* 1:142-143, 1971.
5. Higgins, M. W., Keller, J. B.: Predictors of mortality in the adult population of Tecumseh. *Arch. Environ. Hlth.* 21:418-424, 1970.
6. Veterans Administration Study: *JAMA* 213:1143-1152, 1970.
7. Hood, B., Bjork, S., Sannerstadt, R., et al: Analysis of mortality and survival in actively treated hypertensive disease. *Acta. Med. Scand.* 174:393-405, 1963.
8. Breckenridge, M. B., Dollery, M. B., Parry, E. K.: Prognosis of treated hypertension. *Quart. J. Med.* 39:411-429, 1970.
9. Hunter, A.: Letter to Editor. *JAMA,* July 5, 1941.
10. Build and blood pressure. *Soc. of Act.*, Vol. I, Chicago, 1959.
11. Quoted in Med. Wrld. News 4:50, 1963.
12. Stamler, J., Berkson, D. M., Levinson, M., et al: Coronary artery disease. *Arch. Environ. Hlth.* 13:322-335, 1966.
13. Moyer, J. H., Heider, C., Pevey, K., Ford, R. V.: The Effect of treatment on the vascular deterioration associated with hypertension, with particular emphasis on renal function. *Am. J. Med.*, 24:177-191, 1970.
14. Page, I. H., Taylor, R. D.: Pyrogens in the treatment of malignant hypertension. *Mod. Con. Card. Dis.* 18:51-52, 1949.
15. Robinson, S. K.: Coronary Artery Disease and Antihypertensive Drugs, *J. Clin. Pharm.* 123-126, 1972.
16. Poll on Medical Practice: *Mod. Med.* 38:17-26, 1970.
17. Morrison, L. M.: A nutritional program for prolongation of life in coronary atherosclerosis. *JAMA,* 150: 1425, 1955.
18. Rinzler, S. H.: Primary prevention of coronary heart disease by diet. *Bull. N.Y. Acad. Med.* 44:936, 1968.
19. Gottheiner, V.: Long-range strenuous sports training for cardiac reconditioning and rehabilitation. *Am. J. Cardiol.* 22:426-435, 1968.

Twenty Six Clinics for Crippled Children

Twenty six clinics for Illinois' physically handicapped children have been scheduled for September by the University of Illinois, Division of Services for Crippled Children. The Division lists twenty-one general clinics providing diagnostic orthopedic, pediatric, speech and hearing examination along with medical social, and nursing services. There will be four special clinics for children with cardiac conditions, and one for children with cerebral palsy. Any private physician may refer to or bring to a convenient clinic any child or children for whom he may want examination or consultative services.

Sept. 6—Hinsdale—Hinsdale Sanitarium
Sept. 6—Carmi—Carmi Township Hospital
Sept. 7—Sterling—Sterling Community Hospital
Sept. 7—Effingham—St. Anthony Memorial Hospital
Sept. 8—Chicago Heights Cardiac—St. James Hospital
Sept. 12—Peoria—St. Francis Hospital
Sept. 12—E. St. Louis—Christian Welfare Hospital
Sept. 13—Joliet—St. Joseph's Hospital
Sept. 13—Champaign-Urbana — McKinley Hospital
Sept. 14—Springfield—St. John's Hospital
Sept. 14—Macomb—McDonough District Hospital
Sept. 14—Anna—Union County Hospital
Sept. 18—Peoria Cardiac—St. Francis Hospital
Sept. 19—Rock Island Area General-Moline Public Hospital
Sept. 19—Alton Memorial Hospital
Sept. 20—Evergreen Park—Little Company of Mary Hospital
Sept. 20—Jacksonville—Norris Hospital
Sept. 21—Elmhurst Cardiac—Memorial Hospital of DuPage County
Sept. 21—Decatur—Decatur Memorial Hospital
Sept. 21—Rockford—Rockford Memorial Hospital
Sept. 22—Chicago Heights Cardiac—St. James Hospital
Sept. 26—Peoria General—St. Francis Hospital
Sept. 26—Belleville—St. Elizabeth's Hospital
Sept. 27—Elgin—Sherman Hospital
Sept. 27—Springfield Pediatric Neurological-Diocesan Center
Sept. 27—Centralia—St. Mary's Hospital

By Robert R. Hartman, M.D./Jacksonville

Maternal death study Case report No. 6

ONE OF THE FUNCTIONS of the ISMS Committee on Maternal Welfare is to analyze the causes of deaths in Illinois mothers and to determine, if possible, what alterations in management and treatment could have prevented any of these deaths. Each month a case will be presented and discussed in an attempt to promote more modern methods of obstetrical management. It is with extreme gratitude that the assistance of the Illinois Department of Public Health is acknowledged. Without their initial collection and preparation of the cases and protocols these studies would be very limited.

The sixth in a series of case reports

Case Report:

This 35-year-old white married para V gravida VI was complaining of headache, abdominal pain, and dizziness subsequent to a fall in which she struck her head. Vaginal bleeding was occurring with the passage of clots. Blood pressure was 90/40, pulse 110 respiration 26, and temperature 98.6. She stated that she had been having chills and fever on the morning of admission and that shortly thereafter began to bleed.

Her hemoglobin was 9.4 grams on admission. The sclera were icteric, heart and lungs were said to be normal, although heart rate was rapid. The abdomen was distended by a gravid uterus rising half way to the umbilicus with generalized tenderness with rebound was noted. The vagina was filled with foul smelling blood. The cervix was about 3 cm dilated and membranes were bulging. The uterus was the size of a 12 weeks' pregnancy.

Diagnosis of an incomplete septic abortion was made, and the patient was given 1,200,000 units of penicillin intramuscularly and started on an infusion containing one gram of Chloromycetin in 500 cc of 5% glucose and water plus 200 mgm of Hydrocortisone. Using nitrous oxide oxygen anesthesia, a D & C was performed with the removal of a moderate amount of placental tissue. Profuse bleeding occurred and the uterus was packed. She was taken to the intensive care unit. Blood pressure was noted to be 90/50. Her pulse 100, and her temperature 99.6 rectally. She was described as chilling. Cephaloridine one gram was added to the intravenous fluids. The patient was given another 1,200,000 units of penicillin plus 100 cc of whole blood during and after her surgery.

It was determined that the patient had been seen 24 hours prior to admission at the same hospital in the Out Patient Department where she had refused a pelvic examination. She had been told by a physician on duty that if she would not consent to examination, she would have to find another hospital and another doctor. After this present admission, the patient remained in serious condition with temperature spikes to 106 degrees and blood pressure varying from 60/100 to 100 systolic and 30-60 diastolic. Abdomen became distended, blood cultures were taken, and X-rays revealed multiple areas consistent with emboli in both lung fields.

On the 14th postoperative day bowel sounds were lost and X-ray revealed the presence of a large pelvic mass thought to be a pelvic abscess. Wangenstein drainage was started and the patient was maintained on antibiotics. She received 1-2 units of blood per day along with 200 mgm of Hydrocortisone every four hours for the first 72 hours postoperatively. The patient expired on the 30th hospital day. Blood cultures had shown escherichia coli.

Forty-eight hours prior to her death, the patient "in a so-called death bed confession" named an individual whom she stated "stuck a rubber tube into my womb."

Comment: This case raises philosophical and therapeutic questions: It illustrates the plight in which many women find themselves—

(Continued on page 152)

surgical grand rounds

Edited by John M. Beal, M.D.

Surgical Grand Rounds are held weekly on Tuesday at 5 p.m. in the Offield Auditorium at Passavant Memorial Hospital. Patient presentations from Passavant, Chicago Wesley Memorial and the Veterans Administration Research Hospitals form the basis of the discussions. This case report was part of the Surgical Grand Rounds of April 13, 1971.

Mesenteric Embolus

Case Report:

Dr. George Tolis: A 63-year-old white man was admitted to the Veterans Administration Research Hospital March 31, 1971, with severe abdominal pain. The pain that developed suddenly in the afternoon on the day of admission was located in the periumbilical area and was severe. The patient was restless and unable to find a comfortable position. He vomited once, and then had a normal bowel movement followed by two watery bowel movements during the succeeding two hours. When admitted to the hospital three hours later, he still suffered severe pain. After admission, he had three bowel movements, two of which were bloody.

Significant past history included admission two years earlier to a hospital in Houston with congestive heart failure. At that time he had atrial fibrillation, dyspnea on exertion, and considerable peripheral edema. He was treated with digitalis and diuretics. Also, he was found to be diabetic. A year and a half ago he was admitted to Veterans Administration Research Hospital for the first time with shortness of breath. Again atrial fibrillation was detected. His insulin dosage required adjustment and he was treated with digitalis and diuretics. X-rays were obtained.

Dr. Harold Mathies: Consistent with the story of heart disease, the chest X-ray demonstrates an enlarged heart and dilated pulmonary vessels, which suggests a modest degree of heart failure. The abdominal series films were taken with a diagnosis of abdominal pain, and show a relatively airless abdomen (Fig. 1). There are a few fluid filled loops of bowel, suggesting bowel obstruction with fluid in the loops and there are small air fluid levels. A transabdominal film was made with the patient lying on his back, shot across, parallel to the table, and showed that there is no free air in the peritoneal cavity.



Figure 1. Plain film of abdomen shows little gas in the gastrointestinal tract.

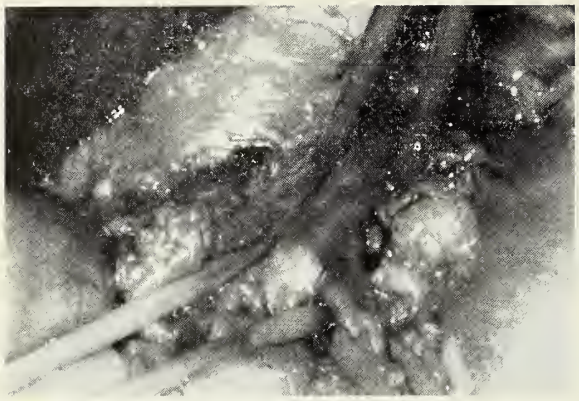


Figure 2. The superior mesenteric artery exposed.

The findings are those of a fluid filled bowel with obstruction.

Dr. Tolis: The physical examination at the time of admission was within normal limits except for an irregular pulse due to atrial fibrillation. Examination of the abdomen was not impressive. The abdomen was soft and localized tenderness or muscular guarding was not elicited. After he had the two bloody bowel movements the pain disappeared, and the abdomen remained soft with some deep tenderness in the right lower quadrant. The blood pressure was 150/90 and the temperature was 98°F. The hematocrit was 50 and the white blood count was 19,000, with a moderate shift to the left. With a diagnosis of mesenteric arterial occlusion, the patient was taken to the operating room eight and a half hours after the onset of pain. The abdomen was opened and the entire small bowel was also reflected to the left. The aorta was palpated and the superior mesenteric artery was identified. The initial two to two and one-half centimeters of this artery was pulsating, but no pulsations could be detected peripherally. It was then obvious that embolus was present in the superior mesenteric artery. The superior mesenteric artery was occluded in its proximal portion and a transverse arteriotomy was made. The embolus was extracted and the arteriotomy closed (Figures 2 and 3).

The operation was the easiest part of management of this patient. Within the first twenty-four hours after operation the patient bled rather severely from his intestinal tract, so that his hematocrit fell from 47 to 25 in 24 hours, requiring four units of blood. Neparin, which had been given during the operation, was withheld. By now his fibrillation was rapid with a ventricular rate of 150, so digitalis was given. On the second postoperative day his gastric output was 4,100 ml in 24 hours and became 5,100 ml on the fifth postoperative day. When analyzed, his gastric secretion was found to be highly acid with pH 1.3, potassium 14, sodium 54 and chloride 170. This made his management more difficult because with a gastric output of 5,100 ml we had to give him approximately 7,000 ml of parenteral fluid a day to cover his losses. As the gastric output subsided, diarrhea appeared.

Now the patient is thirteen days following operation and is doing well. He is taking feedings by mouth, although he still has supplementary intravenous fluid therapy.

Dr. Beal: Dr. Ujiki, would you comment on the diagnosis?

Dr. Gerald Ujiki: When I was called, the patient had already had the bloody bowel movements. The history of atrial fibrillation, the sudden onset of abdominal pain, the elevated white count, and then bloody stools made the diagnosis apparent. Before the bloody stools occurred, a diagnosis of perforated ulcer had been considered. The lack of abdominal rigidity had made perforated ulcer unlikely and a search was instituted to find another cause of the severe abdominal pain.

Dr. Beal: Dr. Hammond, would you comment on this case?

Dr. James Hammond: It was very interesting to have a chance to see this fascinating patient with such a serious surgical disorder, and stay on the side lines and have a chance to appreciate some of the interesting pathophysiology that unrolled before our eyes. Certainly Dr. Tolis and his associates deserve a lot of credit for pulling a patient through with a very difficult problem. We were first of all speculating as to the etiology of his gastric hypersecretion, which first appeared on his second postoperative day. We have no information about his secretory status prior to surgery, but during his first postoperative day



Figure 3. The embolus is visible in the arteriotomy which has been made in the superior mesenteric artery.

he put out a volume of only 850 ccs, probably below the normal range. It was on his second postoperative day with a volume of 5,000 ccs, and the third postoperative day with a volume of 4,625 ccs that hypersecretion began. We have followed gastric secretion in a number of patients postoperatively, and never before have seen persistent hypersecretion, certainly of this degree. In speculating about this, it appeared that it was consistent with the kind of hypersecretion seen in patients with massive resections which vary in the onset and in the duration, and usually are transient and usually involve an increase in the basal secretion. In contrast, following experimental intestinal resection, dogs seem to develop no increase in basal secretion, but hypersecrete in response to stimuli. The speculation ran then, that this patient probably was losing a lot of his intestinal mucosa and might, at least temporarily, function like a patient who has had an intestinal resection. The mechanism of this post-resection hypersecretion is unknown. It is interesting that dogs have shown a reduction in their experimentally induced gastric hypersecretion if an Antrectomy is done. This suggests that intestinal resection eliminates an inhibitor of gastric release. We thought it would be interesting if we could get serum gastric levels on this patient during and following the period of hypersecretion, if possible.

The second item was the onset of diarrhea, an increase in stool volume which coincided with the onset of oral intake. As Dr. Tolis pointed out to me, this has been observed in a few patients who had embolectomies and have not had resections, and it is presumed to be due to malabsorption. Two patients have been studied rather carefully over a period of a year. They had generalized malabsorption for a period of some months following surgery, and when tested a year later, both were normal. This is presumably related to ischemic injury, but obviously it is a complicated picture. The intestinal cells present at the time of the embolectomy certainly have long since been replaced. Yet it is known that other organs, such as the liver, show sustained malfunction after ischemic injury. It seems probable that this is the etiology of this patient's increased stool volume. We hope to document this with appropriate studies which demonstrate malabsorption.

Dr. Beal: Dr. Bergan, this is a subject of interest to you.

Dr. John Bergan: Although problems of intestinal ischemia are still more undefined than those of arterial insufficiency in the periphery, some answers are now being found. One of the intestinal ischemia syndromes which is defined is this one: acute mesenteric artery embolization.[1] This is a diagnosis which can be made over the telephone in a typical case. This is a very typical presentation. Just to review, this man had the usual history of acute onset of severe catastrophic abdominal pain in a patient with auricular fibrillation. Then the pain was followed by the gastrointestinal emptying including a normal stool and then diarrhea and vomiting. This is the mesenteric embolus triad.[2]

What intrigues me is the magnitude of the ischemia that was present in this case. After only eight and one-half hours of deprivation of the blood supply to the mesenteric artery, the patient sloughed sufficient mucosa to have a massive postoperative intestinal bleed. Then there were the manifestations of absent gut, as Dr. Hammond has just pointed out. Finally, there was malabsorption. This shows the tremendous variation in intestinal blood supply that occurs among individuals. We have been taught that a person must have involvement of both the celiac axis and the superior mesenteric artery to produce intestinal ischemia. However, here is a clear cut case where a single artery was occluded for a very brief period of time and this produced profound ischemia.

Our own interest in this was attracted by a similar case, and as we began delving into the subject, we discovered that there were a number of unexplained deaths following intestinal revascularization. In an attempt to define this in the laboratory, we learned about the phenomenon of shock following mesenteric artery declamping in dogs. To make a long story short, dogs and man do not act alike. If you tie off the mesenteric artery in the dog, the intestine goes into intense spasm, the mucosa, which is the big toe of the bowel, sloughs, the dog's intestinal mucosa sheds and he will bleed. If you declamp or revascularize the gut a tremendous hyperkalemia is produced and there is an enormous release of histamine and proteolytic enzymes into the portal circulation. That dog will then go into shock and rapidly die. This does not happen in man. Now we have experience with fourteen cases of intestinal revascularization. The only phenomenon which we did see in one of our cases was transient hyperkalemia. In all other instances, revascularization shock did not occur.[3]

This case was very well handled by Dr. Tolis, and I think it a great tribute to him that the patient survives now. ◄

References

1. Bergan, J.J., Dry, L., Conn, J., Jr. and Trippel, O.H.: Intestinal ischemic syndromes. *Ann. Surg.* 169:120, 1969.
2. Bergan, J.J.: Recognition and treatment of superior mesenteric artery embolization. *Geriatrics* 24:118, 1969.
3. Bergan, J.J., Haid, S.P. and Conn, J., Jr.: Systemic effects of intestinal revascularization. *Amer. J. Surg.* 117:235, 1969.

The Value Of The
On The Incidence Of

By Albert Sion, M.D. and Morris T. Friedell, M.D./Chicago

Many perplexing diseases have been clarified by the geneticist, biophysicist, and biochemist, thereby setting the scientific foundations of medicine on a purely molecular basis. The study of genetics has been most spectacular in this regard during the past two decades.

In multicellular organisms, including man, no more than two forms of the same trait are found in any one organism. This duality in variations recognized by Mendel as an important rule in his introduction of genetic principles implies that a pair of genes affect the same function or inherited trait. Alternate forms of genes affecting the same characteristics are alleles. Individuals who carry two identical alleles (homozygosity) would produce only one species of a particular polypeptide chain. Individuals who carry a pair of different alleles (heterozygosity) will produce two species of a particular polypeptide chain. The alleles, although different in informational content with respect to the amino acid sequence of a given polypeptide chain, affect the same function. Thus, in man, gene pairs control various basic functions; each function is under the control of a particular gene pair.

One of the most striking examples in human genetics is sickle cell disease. Electrophoresis of hemoglobin from red cells of a patient with sickle cell anemia reveals no normal adult hemoglobin. The parents and a number of the patient's siblings show electrophoretic patterns of normal hemoglobin (A) and abnormal (S) in approximately equal amounts (Figure 1).

Chemical examination of hemoglobin-S reveals that amino acid of the alpha chain differs qualitatively from the beta chain of hemoglobin-A. The difference consists of a substitution of the usual glutamic acid in position 6 by a valine. This substitution represents a mutation (Fig. 2D).

In deoxygenated blood of patients with sickle cell disease, the erythrocytes shrink or crumble into crescentic moon shapes. In oxygenated blood the cell assumes the normal form of a bi-concave disc. Twenty years ago Linus Pauling[1] suggested that this sickling might be due to the presence of some chemical abnormalities which would form rods upon deoxygenation, altering the cell out of shape. Perutz[2] found that deoxygenated sickle hemoglobin has a much lower solubility than the oxygenated normal hemoglobin, suggesting that this sickling phenomenon may actually involve a nonspecific crystallization of the hemoglobin in the susceptible cell. Simultaneously, Harris[3] observed spindle-shaped liquid crystals of 1 to 15 microns in the deoxygenated solutions of hemoglobin-S. Ingram[4] provided evidence that the abnormality of hemoglobin-S was due to a substitution in position 6, in which glutamic acid is replaced by valine. However, this simple explanation was not sufficient to explain the biophysical characteristic of the sickling process.

It has long been suspected that the four polypeptide chains are tetrahedrally arranged (Figure 2A[5,6]. According to the Murayama concept[7], the beta chains which form a fairly well defined edge in the molecular model could occupy the lower half of this tetrahedron while the top half is occupied by the two alpha chains (Figure 2B) rotated 70° clockwise with respect to the beta chain half. If the four apices (protecting amino acids) of the original tetrahedrons are cut (Figure 2C) a surface conformation is obtained which agrees reasonably well with the shape of the molecular model. Murayama concluded from stearic conformations that in hemoglobin-S a hydrophobic intramolecular bond could form between the valine in the beta chain and the genetically substituted 6 valine in the same chain (Figure 2E). Therefore, when the valine bond is formed in the beta chain, the molecule changes surface conformation forming a projecting key represented by the triangle filled with broken lines (Figure 2C). The intramolecular bond also could allow cyclization from the first C=O to 4-N-H by hydrogen bonding (Figure 2E). This model indicates the key which

Screening Program Sickle Cell Disease

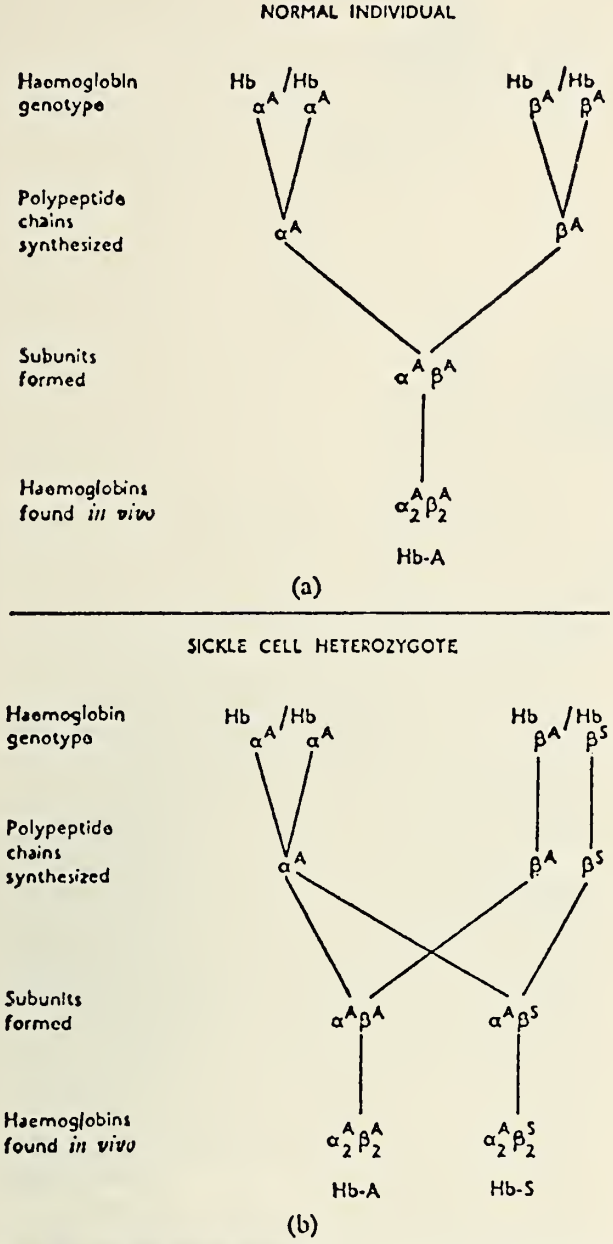


Figure 1. Genetic cantral af hemaglabin synthesis in man. $Hb_{\alpha A}$ is the gene determining the amina acid sequence of alpha palypeptide chains af normal adult hemaglobin (Hb-A). $Hb_{\beta A}$ is the gene determining the sequence of beta polypeptide chains af Hb-A. For further explanatian see Heuhns, E. R., and Shaater, E. M.: "Hemaglabin," Sci. Pragr., 52:353-374, 1974.

could fit into a complementary site in the alpha chain of the adjacent hemoglobin-S molecule[8].

Before the genetic substitution of amino acids in the Hb-S molecule was known, it was observed that this hemoglobin has a negative temperature coefficient of gelation; that is, the deoxygenated hemoglobin solution gels at 38° Centigrade, but melts reversibly when placed in ice[8]. This is one of the indications for the presence of a hydrophobic bond formation. These gels also are weakened when exposed to high hydrostatic pressure of about 200-300 atmospheres, changing from spherulation of the cell and then sickling when the decompression occurs slowly[10,11]. Optical rotatory dispersions at 0° centigrade are essentially the same as in hemoglobin-A, but when the deoxygenated hemoglobin solution is warmed to 38° the rotatory optical dispersion is increased by a factor of 3, indicating that optical activity is increased by bond restriction and consistent with the postulated valine hydrophobic bonding in the beta chain. When the temperatures are lowered the hydrophobic bonds become weaker. This is another proof of the existence of this bond, since the cyclization of a hemoglobin-S molecules occurs at 38° but not at 0°[7].

It has been demonstrated that propane causes unsickling, since it forms competitive hydrophobic bonds with the isopropyl groups of the



Albert Sian, M.D., F.C.A.P., (left) is Directar af the Department of Labaratary Medicine, Jackson Park Haspital. A graduate af the Escuala de Medecina, Antiaquia University, Medellin, Colambia, he taak his residency in pathalagy at Michael Reese and at Duke Univ. Dr. Sion's chief interest is the biachemistry of prateins and genetics.

Marris T. Friedell, M.D., (right) is Medical Directar af Surgery at Jacksan Park Hospital. He received his M.D. fram the University af Minnesota and took his residency at the Maya Clinic.



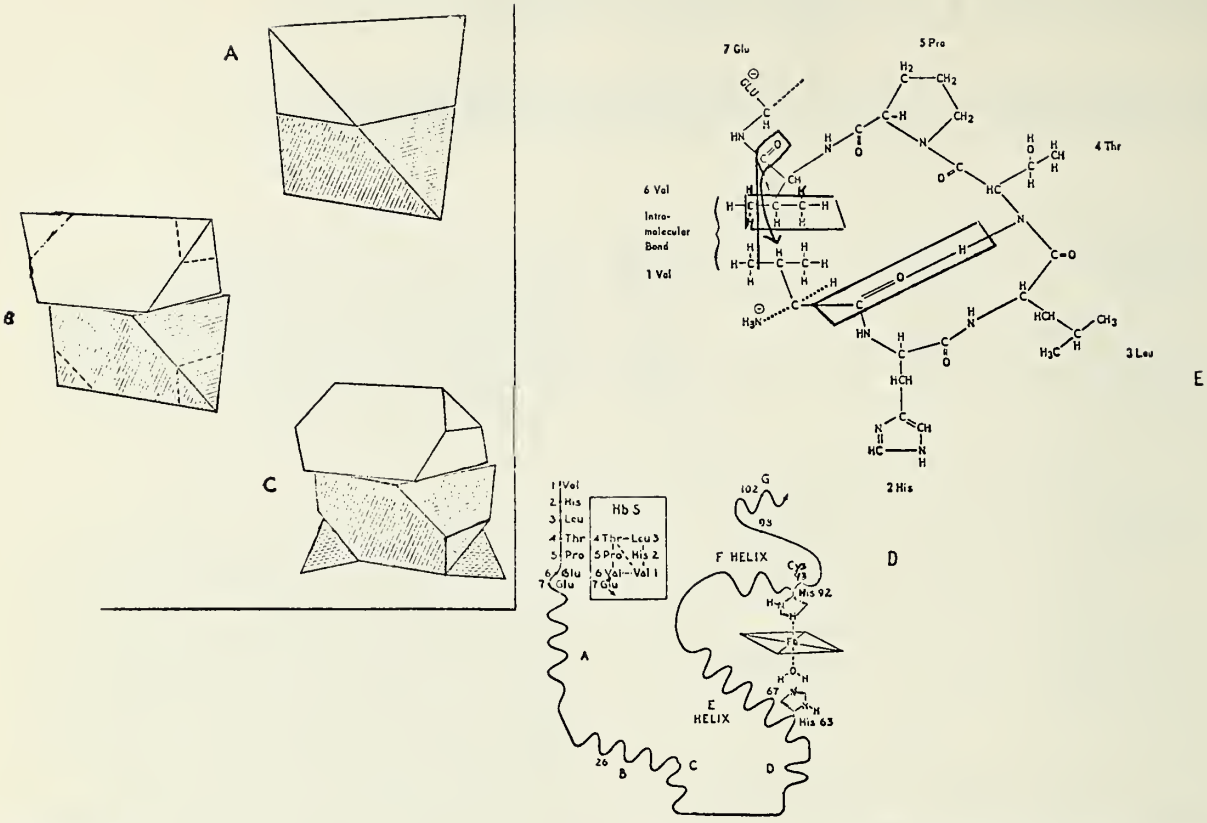


Figure 2.

valine site chain residual blocking the intramolecular valine value interaction. In effect this propane action has been demonstrated with hemoglobin-S but not with hemoglobin-C in which the nature of the bond is of the ionic type. The proposed cyclization allows a lock and key formation permitting molecules to mate in complementary fashion with a head to tail stacking resulting in hemoglobin-S filaments[8].

According to the Hardy-Weinberg Law, the random mating of two alleles, A and a (Figure 3), of a gene present in the proportion of pA and qa will be distributed in the population $(pa + qa)^2 = p^2AA + 2pqAa + q^2aa$. Calculations show that the heterozygote has a dilutional factor of −6 indicating that the trait has a tendency to dilute at a high rate, while the homozygote has a factor of −1 indicating that the genetic penetration of the disease becomes highly diluted as the population increases and has the tendency to disappear (Figure 4).

The Jackson Park Hospital, with 222 beds, is situated on the south side of Chicago, where a large percentage of the population is Black. A screening program for the systematic detection of sickle cell disease was developed in 1968.

Table I indicates the increasing frequency in the occurrence of sickle cell disease in the patient population—about 6,000 admissions per year.

	Parent 1		Parent 2	Parent 1		Parent 2
Genotypes of parents	Aa	x	aa	Aa	x	Aa
Gametes of parents	A a		a	A a		A a
Possible genotypes of progeny	Aa		aa	AA	Aa Aa	aa
Possible phenotypes of progeny	A		a	A	A	a
Phenotype frequencies	½		½	¾		¼

Figure 3. Gene segregation for a single pair of alleles in two different types of mating. "A" is a dominant gene and "a" is a recessive gene. "A" and "a" are alleles.

In every Black patient who has 10 gm. of hemoglobin or below, disregarding the admitting diagnosis, a sickle cell test is performed. The use of the solubility test is preferred because it takes only two minutes, is a simple technique, does not require a microscope, and is low in cost. In

TABLE I

Year	Cases
1964	1
1965	1
1966	5
1967	12
1968	12
1969	44
1970	43
1971 (June 15)	18

$(AAP + aaQ)^2 = .01P^2 + .12PQ + .36Q^2 = 0$

$(.1P + .6Q)(.1P + .6Q) = 0$

$.1P = -.6Q \quad .1P = -.6Q$

$P = \frac{-.6Q}{.1} \quad P = \frac{-.6Q}{.1}$

$P = -6Q \quad P = -6Q$

$Q = -P/6 \quad Q = -P/6$

Q	P
1	-6
2	-12
3	-18
4	-24
5	-30
6	-36
7	-42

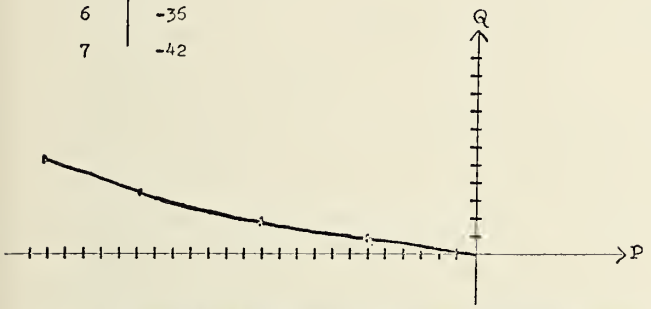


Figure 4. Hardy-Weinberg Law indicates that in random mating two alleles (A and a) of a gene present in the proportion pA and qa will be distributed in the population $(pa + qa)^2 = p^2AA + 2pqAa + q^2aa$.

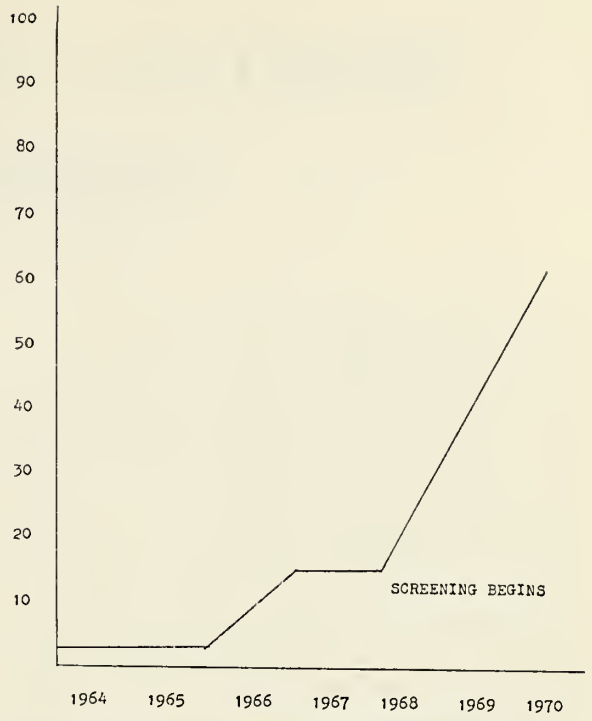


Figure 5. The screening program on the incidence of Sickle Cell Disease at Jackson Park Hospital from 1964 to 1970.

each case in which the solubility test is positive, a hemoglobin electrophoresis is performed.

It is a known fact that Hb-S is less soluble than Hb-A. Yakulis and Heller in 1964[12] mentioned a hemoglobin-S solubility test on this basis, but the test never became popular. One ml. of whole blood obtained from a patient's finger is mixed with 2 ml. of a buffered solution* in a small test tube. After two minutes the degree of cloudiness of the hemoglobin suspension is read macroscopically and compared with a positive hemoglobin-S and a negative hemoglobin control. The less soluble hemoglobin-S is indicated by a cloudy and turbid suspension.

*This buffered solution contains potassium phosphate, sodium dithionite and saponin.

Summary and Conclusion

The biophysical presence of a hydrophobic bond between valine 6 and valine 1 produces projecting keys locking into a receptive complementary chain (key and lock concept) forming the microtubules demonstrable by electron microscopy. These projecting keys can be broken by urea, propane and high atmospheric pressures.

An organized screening program at the Jackson Park Hospital since 1968 has detected 117 cases of sickle cell disease in patients admitted with a hemoglobin of 10 gm. or less. Application of the Hardy-Weinberg Law shows that the heterozygous trait has a tendency to dilute into the population by a factor of −6, while the homozygous will disappear or dilute with a factor of −1. ◄

References

1. Pauling, L.: Abnormality of hemoglobin molecules in hereditary hemolytic anemias. *Harvey Lect.* (1953-1954) 49:216-241, 1955.
2. Perutz, M. F., Mitchison, J. M.: State of haemoglobin in sickle-cell anaemia. *Nature (Lond)* 166:677-79, 1950.
3. Harris, J. W.: Studies on destruction of red blood cells; molecular orientation in sickle cell hemoglobin solutions. *Proc. Soc. Exp. Biol. & Med.* 75:197-201, 1950.
4. Ingram, V. M.: Gene mutations in human haemoglobin: The chemical difference between normal and sickle cell haemoglobin. *Nature (Lond)* 180:326-28, 1957.
5. Perutz, M. F.: Structure and function of haemoglobin. I. A tentative atomic model of horse oxyhaemoglobin. *J Molec Biol* 13:646-68, 1965.
6. Perutz, M. F.: X-ray analysis of haemoglobin. *Nature (Lond)* 149:491-94, 1942.
7. Murayama, M.: A sub-molecular mechanism of gel formation in sickle cell haemolysate. *Nature (Lond)* 194:933-34, 1962.
8. Murayama, M.: Titratable sulfhydryl groups of normal and sickle cell hemoglobins at 0° and 38°. *J Biol Chem* 228:231-40, 1957.
9. Marsland, D.: Protoplasmic contractility in relation to gel structure: Temperature-pressure experiments on cytokinesis and amoeboid movement. *International Review of Cytology* 5:199-227, 1956.

(Continued on page 160)

Society of Critical Medicine

By David Allan, M.D./Chicago

The Society of Critical Care Medicine arose from the recognized need of immediate care for critically ill patients. Some four years ago, concern about the care of large numbers of severely ill patients inspired discussions ranging widely over some of the obvious problems associated with medical management, support facilities, personnel, training and logistic needs. The concern by individuals associated with multidisciplinary I.C.U.'s and service I.C.U.'s (trauma services, pediatric I.C.U.'s, coronary care units, postanesthetic recovery rooms, etc.) led to the realization that many of these problems could be solved by mutual sharing of ideas and further information.

Max Harry Weil, M.D., Ph.D., Director of the Center for the Critically Ill, Hollywood Presbyterian Hospital, and Associate Professor of Medicine and Director of the Shock Research Unit at the University of Southern California, was elected president. Dr. Weil is a noted scientist, educator, lecturer, and author.

David Allan, M.D., a distinguished pediatric anesthesiologist, and biomedical engineer, who is Chairman of the Department of Anesthesia at Children's Memorial Hospital, and Professor of Anesthesia, Northwestern University in Chicago, was elected secretary-treasurer.

Peter Safar, M.D., a noted authority on critical care medicine, who is Professor and Chairman of the Department of Anesthesiology, University of Pittsburgh, was selected president-elect.



DAVID ALLAN, M.D., is heod of the Division of Anesthesiology, and Medical Director, Department of Respiratory Therapy, Children's Memoriol Hospitol, Chicogo. He is olso o professor of onestesiology, Northwestern University Medicol School. An author of severol papers on vorious concerns in pediotrics and criticol core, Dr. Allon is o groduote of St. Andrew's University, Scotland. He currently serves as secretary-treasurer of the Society of Critical Core Medicine.

Of special interest to anyone desiring information regarding membership are the following excerpts from the Constitution:

- The purpose of the Society is to improve care for acute life-threatening illnesses and injuries, and to promote the development of optimal facilities for this purpose.
- The Society is a non-profit organization incorporated as such under the laws of the state of Illinois.
- Qualified for membership are the following: physicians, scientists, engineers, nurses, and other allied health professionals who spend substantial time in critical care medicine, and who are actively involved in critical care development, patient care, teaching or research. Members are divided into six categories in the Society: physician, scientist, engineer, nurse, respiratory therapist, and technologist. Membership for physicians is based on board eligibility or certification. Furthermore, they should have a state license, and show evidence of high moral, professional, and ethical responsibility. They must also show evidence of one year's training and two years experience in critical care medicine.

Concerned, interested inquiries regarding membership may be directed to: David Allan, M.D., Secretary-Treasurer, c/o Children's Memorial Hospital, 2300 Children's Plaza, Chicago, Illinois 60614. ◄

American College of Cardiology Fellows

Eleven Illinois doctors have been granted Fellowships in the American College of Cardiology (ACC), the national medical society for specialists in cardiovascular diseases. Admitted to the college's highest classification were: Lampis Anagnostopoulos, Sidney Levitsky, Kenneth Rosen, Paul W. Saltzman, Constantine J. Tatooles, all from Chicago; Rostam G. Ardekani, Des Plaines; Henry S. Loeb, Highland Park; Peter S. Mayer, Highland Park; Roque Pifarre, Maywood; Sachchida Sinha, Maywood; Michael M. Digilio, Oak Park. The physicians have fulfilled stringent membership requirements based on several years of practice and specialty certification.



editorials

Schools Without Walls

Medical schools without walls, simulated patients and TV lectures could play an increasing role in teaching future physicians. Schools without walls refers to the clinical years that are taught in hospitals and outpatient clinics, far from home base. The students receive their training in the basic sciences at state universities that may or may not have a medical school. From here, the young neophyte is sent to a satellite center to complete training, returning only at commencement to receive an M.D. degree.

The simulated patient is a substitute for the teaching patient that so frequently was found among the medically indigent. He comes by necessity, because today medical students and the house staff care for patients of all walks of life. The simulated (programmed) patient is an individual carefully trained to reproduce faithfully the psychological, emotional, historical, and physical manifestations of a patient on observation and during interview and examination. Howard S. Barrows, in his delightful book, Simulated Patients (Charles C. Thomas, Springfield, Ill., 1971.) used these normal persons for eight years at the University of Southern California School of Medicine. They were, in essence, programmed to be sick.

The method provided information that never was obtained in evaluating medical skills and performance. In addition, it allowed the teacher to bring clinical problems at any time into areas where it was previously impossible or unsatisfactory.

Use of the simulated patient is comparable to Link trainers and cockpit simulators used in teaching pilots to fly. A frequent criticism among students is that "fake" patients are no substitute for the real thing. This is not true, according to Barrows. It is amazing how many different conditions in the various specialties of medicine and surgery can be mimicked successfully. More amazing is the success that some professors have had in presenting a "fake" as a real patient at weekly neurological clinics attended by colleagues, house staff, and students. Cases simulated included multiple sclerosis, peripheral polyneuropathy, cerebrovascular disease, cerebellar tumors, psychomotor seizures, subarachnoid hemorrhages, coma with decerebrate rigidity, and migraine headache.

The secret is the recruiting of effective and versatile simulators. Actors, actresses, and drama students can be taught without much trouble. A flair for acting is important. The repertoire may be limited but it is surprising how few mistakes are made. Professional simulators also are great in teaching anatomy and physical diagnosis.

The use of videotape as a teaching tool (often with simulators) cannot be underestimated. It is likely that future lectures from our very best teachers will be filmed and relayed to all medical schools. Anatomy and physical diagnosis also lend themselves to this approach. In this way, the size of the faculty can be reduced to a minimum and the students will have the opportunity to be taught by the finest instructors. When simulated patients are used, the lecture may assume a more professional air.

As an alternate, medical students could be taught over closed circuit TV. The lectures could be live or taped and sent simultaneously by cable to all medical schools. Reruns could be used for subsequent classes.

Some educators will take a dim view of these suggestions. Teaching methods may change, but not the student. Videotapes and TV are wonderful, but as soon as the lights go out, the student invariably falls asleep.

T. R. Van Dellen, M.D.
Editor

the view box

Leon Love, M.D./Chairman/Department of Radiology
Loyola University Stritch School of Medicine

This 20 year old female patient has had a history of dysphagia for the past five years. She has no symptoms. What's your diagnosis?

1. Carcinoma of the esophagus
2. Caustic esophagitis
3. Barrett's esophagus
4. Peptic esophagitis

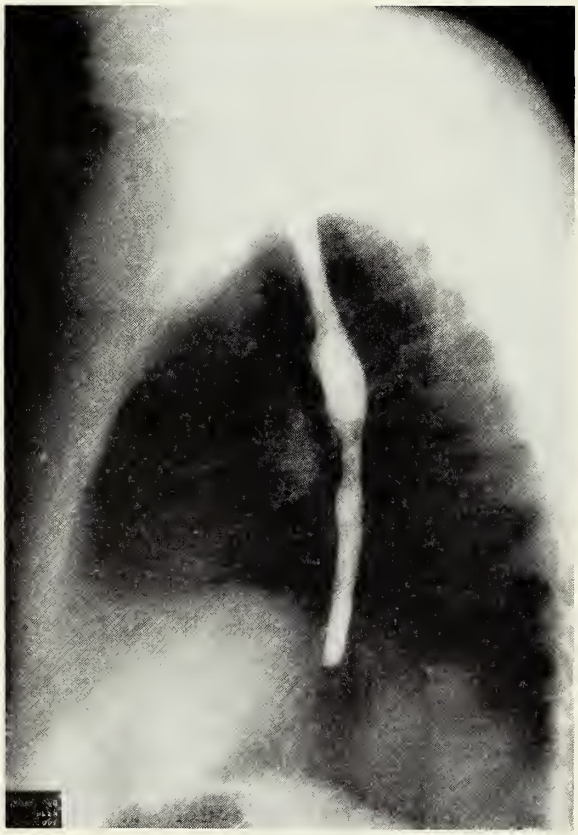


Figure 1.

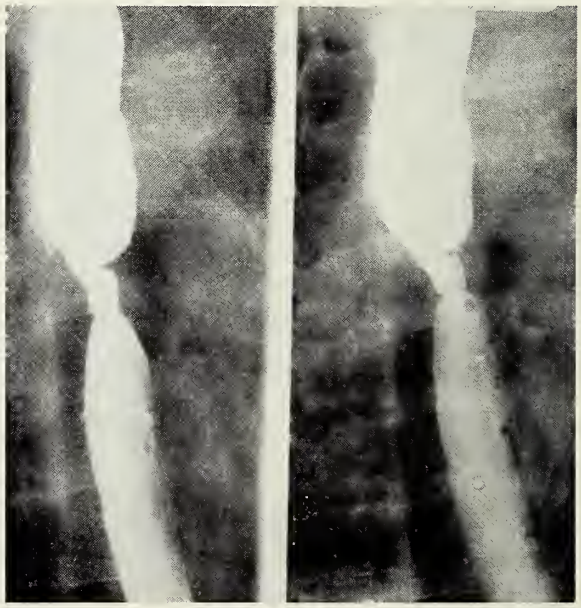


Figure 2.

(Answer on page 152)

Elective Interval Appendectomy For Recurrent Right Lower Quandrant Pain

Should the Asymptomatic Patient Have Surgery?

By George W. Abatso, M.D./Chicago

Elective interval appendectomy is a widely accepted practice which is traditionally reserved for some cases of appendiceal abscess and appendiceal granulomas.[1,2] In the operating room, however, this practice gains a much wider application, and it is extended to cases of recurrent, right lower quandrant pain which subside spontaneously. These cases are very frustrating to many surgeons and the gravity of the frustration is underscored by some of the reasons given by surgeons to justify surgery. The following case history illustrates the frustration of the surgeon.

An 18-year-old man was admitted to another hospital with history of recurrent right lower quandrant pain. He actually had two episodes of right lower quadrant pain, the last of which was two weeks prior to admission. There were no symptoms at the time of admission and physical examination was completely normal. The patient was operated on the next morning and a normal appendix was removed.

The surgeon's reasons for operating were that the patient had had two attacks of right lower quandrant pain and that the patient was going away to college. Unfortunately, the literature is quite silent on the subject and offers no clear guide. As such, the following review is undertaken to find an answer to what a surgeon should do with these cases of recurrent right lower quandrant pain.



GEORGE W. ABATSO, M.D., is a surgical resident at Mt. Sinai Haspital and Medical Center, Chicaga. He received his M.D. degree fram the Chicaga Medical Schaal.

Material and Method

The records of 1,530 primary appendectomies performed at Mount Sinai Hospital, Chicago, from 1961 to 1969, were reviewed; those done as elective interval appendectomies were collected for analysis. Included are the following types of cases: 1) Cases diagnosed initially as either appendiceal granuloma or abscess, which were treated conservatively and readmitted later for interval appendectomy; 2) Cases with a history of recurrent right lower quadrant pain who were admitted during the time of one such attack but operated electively; 3) Cases with the history of recurrent right lower quandrant pain admitted electively while asymptomatic and operated upon. The pathology findings were categorized into three groups as shown in Fig. 1, a modified version of Kazarian, et al.[8] Also, cases were analyzed with regard to age and sex.

Results

Of the 1,530 primary appendectomies, 38 were done as elective interval appendectomies, an incidence of 2.5%. Three of these initially had local abscess treated with simple drainage at the time, and one had appendiceal granuloma treated conservatively with antibiotics. There were 16 males and 22 females; however, there

FIGURE I. CLASSIFICATION OF FINAL PATHOLOGY DIAGNOSIS

Class I	Class II			Class III	
NORMAL	MINIMAL PATHOLOGY FINDINGS			SIGNIFICANT FINDNGS	
No Abnormal Finding	Lymhoid & Reactive Hyper-Plasia	Sub-Mucosal Fibrosis	Fibrosis Obliberation of Lumen	Chronic Inflammation	Acute & Sub-Acute Inflammation

Classification used for evaluating the pathology findings—Class I—Normal, indicates no diagnostic abnormality. Class II—Minimal Pathology indicates appendices showing lymphoid or reactive hyperplasia, focal sub-mucosal fibrosis and fibrous obligeration of the lumen. Class III—Significant Pathology indicates acute, or sub-acute or chronic inflammation of the appendix.

FIGURE 2. SEX INCIDENCE AND ASSOCIATED PATHOLOGY DIAGNOSIS

Sex	No. Cases	Class I Normal	Class II Minimal Disease	Class III Significant Disease	Percentage of Sign. Dis.
M	16	6	6	4	25.0%
F	22	9	7	6	27.3%
TOTAL	38	15	13	10	26.3%

Sex incidence of recurrent right lower quardant pain, and final finding at surgery. Note that there is no significant difference in the incidence of diseased appendices between the sexes.

was no significant difference in the incidence of pathologic findings between the sexes (Fig. 2). Ages ranged from 10 to 63 years, with the majority of cases between the ages of 11 and 30 (Fig. 3).

Of the 38 cases, 15 (39.5%) had normal findings and 13 (34.2%) had minimal pathologic findings, while 10 (26.3%) showed significant pathologic findings (Fig. 4). To divide the total cases into categories, there were four cases in category one, those with previous abscess. Of those four, one had normal appendix, one had minimal pathology, and two had significant pathology. In category two, those with recurrent right lower quandrant pain admitted with symptoms, there were 10 cases, of which one had normal appendix (10%), five (50%) had minimal pathology, and four (40%) had significant pathology, (Fig. 5-A). In category three, those who had recurrent right lower quandrant pain admitted electively without symptoms, there were 24 cases, of which 13 (54.2%) had normal appendix, seven (29.2%) had minimal pathology, and four (16.6%) had significant pathology, (Fig. 5-B). The one significant observation in this analysis is the difference between categories two and three, which suggests that patients with recurrent abdominal pain should probably be treated during the attack.

Discussion

The literature is quite silent on the subject of elective appendectomy for recurrent abdominal pain. A few authors remarked about the problem of recurrence in cases of clinically diagnosed appendicitis treated conservatively.[2,4,5] On the other hand, interval appendectomy for appendiceal granuloma and local abscess from perforated appendix have been discussed adequately.[1,2,10] Because of a reported high rate of recurrence (67%)[2], (23%)[4], it is suggested that interval appendectomy be done following recovery with conservative management.[10] Most authors recommend a six week interval. Other authors[1,9] recommend a conservative approach of observing the patient on an out-patient basis and doing an appendectomy if and when recurrence occurs. This approach is sound in that only those with recurrent attacks would undergo surgery.

It fails, however, to answer the question of what a surgeon should do for a patient who has had two or three episodes of right lower quandrant pain, all of which subsided spontaneously. Bogart and Sebesta[3] recommended incidental appendectomy as a form of prophylaxis against appendicitis. To be emphasized is the fact that such a prophylactic procedure is incidental to other intra-abdominal procedures, and that it consti-

FIGURE 3. AGE DISTRIBUTION AND ASSOCIATED PATHOLOGY DIAGNOSIS

Age	No. Cases	Normal App.	Minimal Path.	Significant Path.
0-10 yrs	1	0	1	0
11-20	26	11	7	8
21-30	7	3	3	1
31-40	2	0	1	1
41-50	1	0	1	0
51-60	0	0	0	0
61-70	1	1	0	0
Total	38	15	13	10

Age distribution of recurrent right lower quardant pain and associated pathologic findings. Note that the bulk of the patients (26) are in the second decade. No significant pattern in the pathology findings.

FIGURE 4. PATHOLOGY DIAGNOSIS

	Class I	Class II			Class III	
	NORMAL	MINIMAL PATHOLOGIC FINDINGS			SIGNIFICANT FINDINGS	
	No Abnormality	Hyperplasia	Sub-Mucosal Fibrosis	Obliterative Fibrosis	Chronic Appendicitis	Sub-Acute & Acute Appendicitis
No. Cases	15	5	5	3	6	4
Total No. Cases	15		13		10	
PerCent	39.5%		34.2%		26.3%	

Total range of final diagnosis—Note that 39.5% are normal, and a total of 60.4% are either minimally diseased or significantly diseased.

tutes no additional risk to the patient.[3] One can hardly recommend primary appendectomy as prophylaxis, innocuous though it may appear, for this innocuous procedure has its mortality and morbidity.[6] Yet, it is also noted that morbidity associated with appendicitis is increasing, primarily due to delaying surgical intervention,[8] and if this trend is to be halted prompt surgical intervention must be exercised. The same cannot be applied blindly to the few troublesome cases of recurrent right lower quandrant pain.

One observation of interest in this analysis is that patients with the history of recurrent right lower quandrant pain who were admitted during one such attack but operated electively during the same hospitalization have an incidence of 10% normal appendices, the same as that in the usual cases of acute appendicitis.[7,11] Compared to this is the high incidence of normal appendices (54%) found in those cases of recurrent right lower quandrant pain who were asymptomatic at the time of admission and operation. This observed difference between the symptomatic and the asymptomatic patient indicates that the patients with recurrent right lower quandrant pain should be treated surgically at the time of an attack if and when it occurs.

Summary

1. The records of 1,530 appendectomies have been reviewed and 38 cases done as elective interval appendectomies have been analyzed.
2. The bulk of the patients who fall in this group range in age from 11 to 30.
3. The patients admitted with symptoms show a 10% incidence of normal appendices, while those admitted with no symptoms have 54% incidence of normal appendices.
4. It is recommended that these patients with recurrent right lower quandrant pain be treated surgically at the time of an attack if and when it occurs. ◄

Acknowledgment

The author wishes to express his gratitude to Dr. William Thomas in the Department of Pathology, Mt. Sinai Hospital, for his counsel during this review.

References

1. Barnes, B. A., Behringer, G. E., Whellock, F. C. & Wilkins, E. W.: "Treatment of Appendicitis at Massachusetts General Hospital," 1937-1959, *JAMA* 180:122, 1962.
2. Befeler, D.: "Recurrent Appendicitis and Prophylaxis," *Arch. Surg.* 89:666, 1964.
3. Bogart, J. N., Sebesta, D. G.: "Incidental Appendectomy and Its Effect on the Incidence of Wound Infection in Cholecystectomy," *Amer. Surg.* 35:650, 1969.
4. Brumer, M.: "Seasonal Incidence and Post-Operative Wound Infection," *Br. J. Surg.* 57:93, 1970.
5. Howie, J. G. R.: "The Place of Appendectomy in Treatment of Young Adult Patients with Possible Appendicitis," *Lancet* 1:1365, 1968.
6. Jerman, R. P.: "Removal of the Normal Appendix: The Case of Serious Complications," *Br. J. Clin. Pract.* 23:466, 1969.
7. Jones, P. F.: "Acute Abdominal Pain in Childhood, with Special Reference to Cases not due to Acute Appendicitis,' *Br. Med. J.* 1:284, 1969.
8. Kazarian, K. K., Roeder, W. J., & Mersheimer, W. L.: "Decreasing Mortality and Increasing Morbidity from Acute Appendicitis," *Am. J. Surg.* 119:681, 1970.
9. Leffall, J. D., Jr.: "Appendicitis: A Continuing Surgical Challenge," *Amer. J. Surg.* 113:654, 1967.
10. Talbert, J. L.: "Appendicitis: A Reappraisal of an Old Problem," *Sur. Clin. N. Amer.* 46:1101, 1966.
11. Winsey, H. S. & Jones, P. F.: "Acute Abdominal Pain in Childhood: Analysis of a Year's Admissions," *Brit. Med. J.* 1:653, 1967.

FIGURE 5. SYMPTOM VS. NO SYMPTOM WITH ASSOCIATED PATHOLOGY DIAGNOSIS

No. Cases	Normal Appendix	Minimal Pathology	Significant Pathology
10	1	5	4
%	10%	50%	40%

A-Symptomatic

No. Cases	Normal Appendix	Minimal Pathology	Significant Pathology
24	13	7	4
%	54.2%	29.2%	16.6%

B-Asymptomatic

Pathology findings in symptomatic and asymptomatic cases. Note that A—which shows symptomatic cases, only 10% have normal appendix, while in B—the asymptomatic cases, 54.2% have normal appendix.

what goes on

a guide to continuing education

August 25—La Leche League of Illinois
Fourth Annual Statewide Meeting
La Leche League leaders and mothers will meet to hear forty sessions ranging from "Breast-feed: Why and How?" to "Clinical Problems/Handicapped mothers—Epilepsy, Hepatitis, Cleft Palate Baby, and Blindness." Sessions will be conducted by both La Leche League leaders and its Professional Advisory Board. Any interested medical professionals or lay workers in health services are welcome to attend.
Contact: Mrs. John R. Kurinsky, 8939 Meade, Morton Grove, Illinois, 60053.
Sheraton O'Hare Motor Hotel, Rosemont, IL

August 28—Loma Linda School of Medicine Alumni Association
"Oriental Adventure" Medical Seminar
Tour will include Japan and Hong Kong
Cost: $878 per person; $30 medical registration fee.
Contact: Alumni Association, Loma Linda, University School of Medicine, 1832 Michigan Avenue, Los Angeles 90033

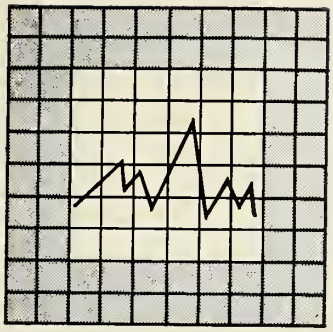
August 28-30—Association of Canadian Medical Colleges
The Fourth Pan American Conference on Medical Education
The conference will have representatives from many countries in the western hemisphere and it is imperative that greater dialogue should take place between the medical schools so that all aspects of the modern educational process can be discussed. The conference theme is "The Role of Education Research in Decision-Making in Medical Education."
Contact: Marna Robertson 928-2722
Toronto, Canada

August 28-September 1—American Academy of Orthopaedic Surgeons Committee on Injuries
Emergency Care and Transportation of the Sick and Injured
The purpose of the course is to teach the important fundamentals necessary for accurate preliminary evaluation of the sick and injured; to teach techniques of emergency care to save life and prevent additional injury or complications; to develop judgment in determining the method and time of transportation to established medical facilities.
Contact: Coordinator: Emergency Care Conf., The Wisconsin Center, 702 Langdon Street, Madison, Wisconsin 53706
Madison, Wisconsin

September 1—American College of Physicians
34 Postgraduate Courses—38 Regional Meetings
The American College of Physicians' one-to-three-day Regional Meetings are designed to help practicing internists (and physicians in related specialties) keep abreast of new developments in the basic sciences and clinical medicine. These meetings serve a double purpose. For one, they bring new advances in medical research from major research centers to local internists who find it difficult to travel to medical meetings outside of their own state. The sessions also provide a means for practitioners in the region to report to their colleagues on investigative work and clinical experiences of their own.
Averaging two-to-three days in duration, the ACP Postgraduate Courses provide opportunities for in-depth study of a wide range of subjects of importance to practicing physicians.
Registration fee: ACP Members and Fellows, $80; Nonmembers, $125; Associates, $40; Other Residents and Research Fellows, $80.
Contact: Registrar, Postgraduate Courses. American College of Physicians, 4200 Pine Street, Philadelphia, PA 19104

September 5-9—International Society of Internal Medicine
1972 International Congress for Internists
The scientific program, focusing on man's relationship to specific factors affecting his health, is expected to attract more than 2,500 specialists in internal medicine and related fields from 47 countries. Major sections will be on Man and His Genetic Environment, Man

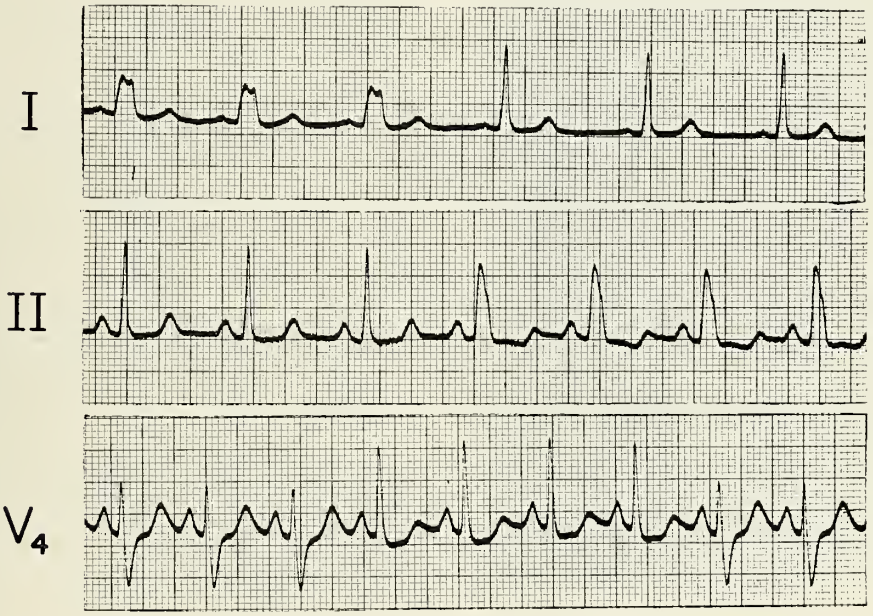
(Continued on page 151)



ekg of the month

John R. Tobin, Jr., M.D., M.S., Rimgaudas Nemickas, M.D., Patrick Scanlon, M.D., John F. Moran, M.D. and James V. Talano, M.D./Section of Cardiology, Loyola University Stritch School of Medicine

A 45 year old man was admitted for an elective hemorrhoidectomy and a routine pre-operative electrocardiogram showed the below changes. Aside from the problem of hemorrhoids, the history and physical examination were normal.



A. The electrocardiogram shows:
1. Signs of electrolyte imbalance.
2. Acute anterior wall myocardial infarction.
3. Intermittent bundle branch block.
4. Signs of acute pericarditis.
5. None of the above.

B. The treatment here should:
1. Include cancellation of the proposed hemorrhoidectomy.
2. Be Quinidine or Pronestyl.
3. Be a digitalis preparation.
4. None of the above.

(Answer on page 153)

The Cooper Quiz

A self-assessment quiz pertaining to various subjects as published in current medical literature.

TRUE *or* FALSE?

1. Despite immunization, rubella cases increased in the 1970 years..
2. Lung cancer is more frequent than breast cancer in females.
3. Sodium iodide I_{131} has been the treatment of choice in patients with Graves Disease who were over 40. This age barrier has fallen until now it is freely used in patients of 25 years of age.
4. Patients with Bartters Disease, like patients with hyperaldosteronism, are hypertensive.
5. It would appear that in patients with Bartters Disease it is a defective kidney tubular mechanism that is responsible for some of the changes in the handling of sodium.
6. In overdoses of Darvon, even with ensuing death, blood levels are very low or undetectable.
7. In overdoses of Darvon, the convulsions, but not the apnea, are controlled by Nalorphene.
8. Tallitoxicosis (Thallous sulphate) is not dramatically affected by hemodialysis.

This self-assessment is part of the "Cooper Quiz," a monthly publication of the Department of Medical Education, Cooper Hospital, Camden, N.J. 08103.

All answers are from the "Archives of Internal Medicine," January, 1972.

1. **False**

"That year began with the 41st calendar weeks of 1970 and carried through the 40th week (mid-October) of 1971.

"This is a 20.4% decrease from the previous epidemiologic year, CDC says. It is the first such decrease since rubella was added to the list of reportable diseases six years ago this month.

"These preliminary data, according to the Atlanta center, suggest that the incidence of rubella has been markedly reduced in areas that conducted effective vaccination programs, compared with areas where vaccine usage has been less comprehensive."

(pp. 15-16, col. 3, para. 5)

2. **False**

"Federal statisticians report the leading cancer sites in women are the breast, colon/rectum, uterus, lung, and ovary. In men, they are the lung, colon/rectum, prostate, stomach, and pancreas."

(p. 20, col. 1, para. 4)

3. **True**

"Sodium iodide I_{131} has been employed as a primary mode of therapy in the treatment of Graves' disease for more than 20 years. It has been the agent of choice in patients 40 years and older and in a minority of younger people in whom antithyroid drug therapy or surgery has been inappropriate or has proved unsatisfactory. Since the initial concern over the dangers of I_{131} has not been substantiated by experience, the arbitrary age barriers to its use have gradually fallen; now, most clinics use I_{131} freely in patients beyond the age of 25 years. According to current estimates, more than 300,000 patients have received I_{131} treatment for hyperthyroidism since 1942."

(p. 33, col. 3, para. 1)

4. **False**

"Bartter's syndrome encompasses a group of patients with a unique form of hyperaldosteronism. These patients, many of whom have been seen as children, frequently present with growth retardation, polyuria, and weakness, and have been described in a recent review. They have been observed to be normotensive

and without edema, hypokalemic, insensitive to the pressor effect of infused angiotensin (angiotensin insensitivity) and to have increased plasma renin activity (PRA), increased aldosterone production, and hyperplasia of the juxtaglomerular apparatus of the kidney. Unlike patients with primary hyperaldosteronism who are hypertensive, these patients have normal blood pressure, and in several instances postural hypotension. A further contrast to primary hyperaldosteronism is the presence of high PRA and angiotensin insensitivity. Their normal blood pressure also serves to distinguish Bartter's syndrome patients from those patients with renal artery stenosis or malignant hypertension who otherwise have a similar increase of PRA and angiotensin insensitivity."

(p. 41, col. 2, para. 2)

5. **False**

"Proximal tubular mechanisms appear intact in Bartter's syndrome. An increase in the proximal tubular reabsorption of sodium is part of the response necessary to drastically reduce sodium excretion when salt intake is severely restricted. Bicarbonate is reclaimed in the proximal tubule; in both subjects reported here, the rate of bicarbonate reabsorption was increased. A mild metabolic alkalosis has been common in patients with Bartter's syndrome, which also suggests an increased rate of bicarbonate reabsorption. In addition, these patients have shown no evidence of hyperuricuria, hypercalciuria, aminoaciduria, renal glycosuria, or hyperphosphaturia."

(p. 46, col. 2, para. 2)

6. **True**

"All nine victims were found to have concentrations of propoxyphene in stomach contents, liver, or both. Most victims' gastric contents also contained material suggestive of dissolving drug capsules or undigested food. Failure of the stomach to empty and the relatively high concentration in the stomach wall of patient 1 suggest exceedingly rapid absorption of propoxyphene directly from the stomach, a fact noted previously in laboratory animals. Nevertheless, blood levels of propoxyphene are generally very low or undectable, due to rapid tissue uptake of the drug. Measurable concentrations were attained in liver, brain, and kidney in the brief intervals between ingestion and death in our patients. The amounts sequestered may be substantial."

(p. 65, col. 2, para. 1)

(Continued on page 139)



Prescribe
the discoverer's brand
Totacillin®*
(ampicillin trihydrate)

*capsules equivalent to 250 mg. and 500 mg. ampicillin, for oral suspension equivalent to 125 mg./5 cc. and 250 mg./5 cc. ampicillin.

BMP

Beecham-Massengill Pharmaceuticals
Division of Beecham Inc. Bristol, Tennessee 37620



practice management

Understanding Phase II Controls

By Noel E. Young, Tax Specialist,
Professional Business Management,
67 East Madison Street, Chicago, Illinois 60603

With November of 1971 came the termination of the "Big Freeze" and the commencement of Phase II with a slight limited thaw! There are still tight controls on physician's fees and on salaries paid to employees in the medical field. However, if one refers to mass media, it could be thought that medical professionals were to be little affected by Phase II of the President's new economic program. Most interpretations stressed that the government's Pay Board and Price Commission would devote most of their time and attention to big business and organized labor. The truth of the matter is that Phase II has tremendous impact on all doctors. There are three fundamental reasons for this impact.

Primarily, Phase II rests heavily on voluntary accord with the guidelines issued by the Pay Board and Price Commission. Compliance is urged, however, for the IRS intends to make spot checks on all professionals in the service industries. Secondly, the guidelines that control annual salary increase for employees to 5.5% of their previous earnings is apt to create a platform full of problems.

As long as Phase II lasts, some employees will be prone to expect at least that big a raise each year. Finally, Phase II will require many doctors to keep better records than they have in the past. This aspect is likely to be greater on their salary schedules than their fee schedules. Most physicians have good records of their fees, but now under Phase II, they will also have to keep detailed records of what salary increases they give and when. The entire situation is quite undefined and it leaves considerable room for error of judgment and interpretation for many technical questions about how Phase II will affect doctors still remain unanswered.

Like other professionals, doctors could be caught in a squeeze between the wage guideline of 5.5% and the price guideline of 2.5%. Thus, a substantial part of the physician's cost could rise at 5.5% annually while he is unable to raise fees more than 2.5%.

The difference is supposed to be made up by increased productivity, which has historically risen by an average of 3% a year. But, productivity is hard to measure especially when applied to a well-run doctor's office operating at peak capacity, none-the-less, doctors are going to have to function with guidelines, like them or not. The risk of ignoring the controls of Phase II may not be as great in medicine as in other industries; yet a number of watchdog organizations that presided over medicare and medicade . . . organizations that range from the Senate Finance Committee to the IRS . . . will be watching, carefully.

Next month—a detailed explanation of the guidelines and controls of Phase II. ◄

Cooper Quiz

(Continued from page 137)

7. **False**

"Accumulation of propoxyphene by the brain leads to respiratory center depression. Apnea and coma were seen in patients 7 and 10, and in 13 of 19 other reported cases. Apnea also can be suspected in patients 2 and 5 who were cyanotic at autopsy. Apnea would cause most of the lung findings listed in Table 4 and is the probable cause of death. Failure to find acute degeneration in the proximal tubules of the kidney suggests swift intervention of death without prolonged shock.

(ps. 65-66, col. 3, para. 2)

8. **True**

"Four members of a family afflicted with tallitoxicosis manifested severe peripheral neuropathy characterized by dysesthesias and spotty anesthesia, and three lived to display pathognomonic alopecia. The first patient to become ill was considered to have died of Guillain-Barre syndrome until lethal levels of thallium were demonstrated in postmortem specimens of liver and kidney. One other patient, hospitalized after being considered hysterical, displayed severe neuropathy, ileus, respiratory difficulties, albuminuria, diplopia, and confusion; but after treatment with dithizone, potassium chloride, and charcoal, she recovered except for a residual foot drop. Urine and fecal measurements of thallium showed change in excretion while the patient was on therapy.

"An eight-hour hemodialysis was performed with thallium measurements of the arterial and venous blood samples, as well as in the dialysis bath. Although this procedure demonstrated that thallium is diffusible, the amount removed was less than that excreted in the urine over a 24-hour period. Also, hemolysis followed the dialysis, and severe postural hypotension was noted. Dialysis is not likely to be lifesaving if renal function is intact. Nerve biopsy for light and electron-microscopy demonstrated segmental demyelination."

(p. 103, col. 2, para. 3)

(Ed. Note: If the readers would like to see this feature continued, please drop a note to the *IMJ* office. Thank you.)



Prescribe
the discoverer's brand
Pyopen®*
(disodium carbenicillin)

*vials for injection equivalent to 1 gm. and 5 gm. of carbenicillin.

BMP

Beecham-Massengill Pharmaceuticals
Division of Beecham Inc. Bristol, Tennessee 37620

membership forum

The Editor: April, 1972

In the past, when a "dead-beat" patient refused to pay his bill, he would threaten a malpractice suit. Now that insurance companies pay the bill they have a new method. Get the insurance company's payment or threaten malpractice. The enclosed story is true, the names have been changed to protect the guilty.

With all best wishes, I remain

Sincerely yours,
Roland I. Pritikin, M.D.

H. F. Johnson, M.D.
567 East 12th Street
Chicago, Illinois

March 17, 1969

Mrs. Vera Smith
567 East 11th Street
Chicago, Illinois
Dear Mrs. Smith:

Have again examined your mother, Mrs. Miller, today. When first examined on 7-18-67, the findings were as follows: Right eye, cataract, retinal degeneration, and glaucoma. Left eye, cataract extraction 4 years ago 20/50 vision with glasses. I again urged her to go back to the eye surgeon, who had operated on her left eye, but she insisted that I do it. I, therefore, explained to her, that I would do that type of operation called an extracapsular extraction, and that she might require a needling later. She was scheduled for admission to the hospital on 3-25-69 at which time her family physician will do her history and physical general examination, and I will write her eye history and physical. She is scheduled for cataract extraction—right eye on 3-26-69.

Sincerely yours,
H. F. Johnson, M.D.

Later this letter was received by my office. Since I was on a philanthropic ophthalmological mission abroad, this letter was turned over to my wife for reply.

Mrs. Vera Smith
567 East 11th Street
Chicago, Illinois

July 1, 1969

H. F. Johnson, M.D.
567 East 12th Street
Chicago, Illinois
Dear Doctor Johnson:

I am in receipt of your last statement in the amount of $16.00 which I have no intention of paying. I am so very disappointed in you and your sloppy methods of practicing medicine. I have been told by several leading men in the field of your attempts to remove cataracts. My mother needs her cataract removed, and this time it will not be easy because the eye has been tampered with and the success not so great. Now we are dealing with cataract pieces rather than cataract whole. You have put my mother, Mrs. Miller, through much pain, discomfort and needless suffering. We have also been told that if we wish to make a legal case out of this our insurance diagnosis will bear out the fact that a cataract remains and must be removed.

I would like a check from you for the total sums you have collected from Medicare and Blue Cross. Believe me, this money will not and can never compensate for what has been done, but will only help to apply for the removal of this cataract. Top men in the field of medicine feel your medical license should be looked into. I am in no position to revoke this, only to verify it.

Very truly yours,
Mrs. Vera Smith

My wife's reply was as follows:

July 15, 1969

Dear Mrs. Smith:

Your letter to Dr. H. F. Johnson has been turned over to me for reply.

Dr. Johnson has been sending all removed lenses to the pathological laboratory for the past 23 years. The extracted lens was unusually large. A thicker posterior capsule could then be presumed.

Since the patient, Mrs. Miller, was not brought back by you for a needling, I checked with the colleague who did the needling. He tells me that with correction, Mrs. Miller can now see 20/20 in her right eye, which is much better than the present vision in her left eye performed very nicely four years ago.

Since the Medicare checks were paid into a partnership fund along with the Blue Cross check, I cannot do anything about it. I am therefore sending you checks from my own personal account, made out to you, Mrs. Vera Smith. (Ck. No. 408—$264.00 and ck. No. 409—$70.00.)

I am sure that is the way my husband would want me to handle this extortion. He has never had any ungrateful patients.

Very truly yours,
Mrs. H. F. Johnson

My letter later was as follows:

Dear Mrs. Smith:

This will confirm our several telephone conversations in which you promised to return the money extorted from my wife. You have not done this. I certainly thought I knew people pretty well, but I certainly misjudged you.

Very truly yours,
H. F. Johnson, M.D.

The House of Delegates adopted a memorial resolution to Mrs. Frances C. Zimmer, an ISMS staff member for some 37 years. This letter has been received from her neice, addressed to Speaker Paul W. Sunderland.

May 14, 1972

Dear Dr. Sunderland,

It is with deep appreciation I wish to thank you and the House of Delegates of the Illinois State Medical Society for the beautifully written Memorial Resolution for my aunt, Frances C. Zimmer. It was so thoughtful of your organization to honor her in such a way. I know many of you knew her personally for many years and she was extremely proud and fond of all of you.

I have so many memories of my Aunt Fran in our home here in Northbrook. It is still so hard to realize she is gone and unable to enjoy her retirement. I'll cherish the picture I have of her with twelve doctors taken at the Past Presidents' Gourmet Dinner May 16th, 1970, honoring Dr. Thomsen; along with a heart-warming speech given to her. I also shall prize her lovely bronze and walnut plaque given to her by your House of Delegates.

Now to receive this lovely memorial resolution is indeed a very thoughtful gift. I will have it framed in order to preserve it for her grand niece and nephew—my 13-year old daughter and 15-year old son—both of whom loved her so.

Again, thank you for your thoughtfulness and kindness. Please extend my deepest appreciation to the House of Delegates.

Sincerely,
Lucile Carpenter McKitterick Rosche'

ADDENDUM

In January, we published an article in the *Illinois Medical Journal* (141:216:1972) presenting the latest recommendation by the USPHS for the treatment of gonorrhea in the female.

Hardly had the ink dried on that report when new recommendations appeared, to wit:

1. That 1 gm of probenecid be administered orally thirty minutes before either penicillin or ampicillin. Penicillin or ampicillin are not to be used if the patient evidences allergy to the antibiotics.
2. That, if the patient is allergic to penicillin or ampicillin, or as an alternative to these antibiotics, or if the response to these drugs is not satisfactory, spectinomycin (2 gm for the male and 4 gm for the female) may be given intramuscularly at one session. (N.B. There are reports that 2 gm is as effective as 4 gm in the female.) As another alternative, tetracycline may be given orally (initial dose of 1.5 gm followed by 0.5 gm every six hours for four days; total dose of 9.5 gm).
3. En passant, the recommended dose for the male with gonorrhea has been increased from 2.4 to 4.8 M units of aqueous procaine penicillin, identical to the female. And while on the subject of the male, it is now becoming apparent that, like the female, many males are *asymptomatic*. The presence of g. c. may not be recognized unless proper culture is taken.

We can be sure, as our knowledge increases, that further changes will be recommended in the future.

Edwin J. DeCosta, M.D.



VD TREATMENT

There has been a definite increase in venereal disease throughout the United States. The following article is reproduced from the United States Department of Public Health, Weekly Report, March 11, 1972, because of the confusion concerning correct dosages in the treatment of gonorrhea.

The following represents the recommended treatment schedules for gonorrhea as set forth by the Venereal Diseases Branch, State and Community Services Division, CDC, March, 1972.

For **Neisseria gonorrhoeae** infection, the preferred drug is penicillin or ampicillin. Physicians are cautioned to use no less than the recommended doses of antibiotics..

For Treatment of Uncomplicated Gonorrhea
(Urethral, Cervical, Pharyngeal, or Rectal)

Parenteral—Men or Women: Aqueous procaine penicillin G, 4.8 million units i.m. divided into at least two doses and injected at different sites at one visit, together with 1 gram of oral probenecid, preferably given at least 30 minutes prior to the injection.

or

Oral—Men or Women: Ampicillin, 3.5 grams, with probenecid, 1 gram, administered simultaneously.

Treatment of contacts: Patients with known exposure to gonorrhea should receive the same treatment as those known to have gonorrhea.

When Penicillin or Ampicillin is Contraindicated.* Or when the Above Schedules are Ineffective

Parenteral—Men: Spectinomycin, 2 grams, in one i.m. injection.

Women: Spectinomycin, 4 grams, in one intramuscular injection.

or

Oral—Men or Women: Tetracycline HCl, 1.5 grams initially, followed by 0.5 gram q.i.d. for 4 days, a total dosage of 9 grams. Other tetracyclines are not more effective.

Follow-Up

Follow-up urethral specimens should be obtained from men 7 days after completion of treatment; cervical and rectal specimens should be obtained from women at 7-14 days after completion of treatment.

Complications

Although treatment of complications (gonococcal salpingitis, bacteremia, arthritis, etc.) must be individualized, repeated large parenteral doses of aqueous crystalline penicillin G have been shown to be effective. The efficacy of alternate antibiotic regimens is unproven. Post-gonococcal urethritis can be treated with tetracycline, 0.5 gram, orally q.i.d. for at least 7 days.

Syphilis

All gonorrhea patients should have a serologic test for syphilis at the time of diagnosis. Patients receiving the recommended parenteral penicillin schedule need not have follow-up serologic tests for syphilis. Patients treated with ampicillin, spectinomycin, or tetracycline should have a follow-up serologic test for syphilis each month for 4 months to detect syphilis that may have been masked by treatment for gonorrhea.

Patients with gonorrhea who also have syphilis should be given additional treatment appropriate to the stage of syphilis.

While long-acting forms of penicillin (such as benzathine penicillin G) are effective in syphilotherapy, they have no place in the treatment of gonorrhea.

*Allergy to penicillin, ampicillin, probenecid, or previous anaphylactic reaction.

Postgraduate Courses for Pediatricians and Obstetricians

The Maternal and Child Health Program of the University of California School of Public Health at Berkeley announces postgraduate courses of instruction for pediatricians, obstetricians, and other physicians interested in receiving training in the field of Maternal and Child Health. These programs all lead to the degree of Master of Public Health. Tax-exempt Fellowships are available, consisting of support for the trainee and his dependents, tuition and fees. Applications are being accepted for a group entering in September 1973. For information write to Helen M. Wallace, M.D., School of Public Health, University of California, Berkeley, California 94720.

Doctor's News

DOCTORS' FEES INCREASE LOWER THAN PRICE GUIDELINES—Physicians fees increased 1.37% during the first nine months of the Economic Stabilization Program while the overall Consumer Price Index rose 2.05% during the same period, an AMA study has disclosed. The Physicians' Fee Index is a component of the All Services Index of the CPI. The All Services Index rose 2.16% during the nine months from September, 1971, through May, 1972, compared to 3.03% during the previous nine months from December, 1970, through August, 1971. During the same period, the Semi-Private Hospital Room Index (which is part of the All Services Index) increased by 3.84%, compared to 6.62% for the previous eight months.

The 1.37% rise in Physicians' Fees Index represents an increase of less than one-third of the 4.38% rate increase for the nine months prior to the freeze. This means that the increase in physicians' fees is well within the goal of the Health Services Industry Committee and the Price Commission to reduce the rate of inflation by one-half.

MALPRACTICE SUITS—A resolution urging the Illinois State Bar Association to "establish reasonable guidelines for the detection and elimination of nonmeritorious medical malpractice lawsuits" has been approved by the Illinois House of Representatives. The resolution points out that the rapidly increasing number of such claims is resulting in greater cost of medical care to the patient. For the last five years malpractice insurance rates have gone up nationally an average of 10 percent a year, reflecting both the growing number of malpractice claims and the growing size of settlements. In Illinois alone during the last year, physicians' liability rates have risen 56 percent to 169 percent, depending upon specialty and area of practice.

"We appreciate the moral support of the Illinois House of Representatives in approving the resolution on malpractice claims introduced by Representative O'Brien," said Dr. Frank J. Jirka, Jr., president of the Illinois State Medical Society. "And we stand ready to work with the Illinois State Bar Association whenever and however they desire."

CERTIFICATION PROGRAM FOR PHYSICIANS' ASSISTANTS—A new national project leading to certification of physicians' assistants is being undertaken by the American Medical Association and the National Board of Medical Examiners. Objective of the project is to determine the best way of developing nationally validated certifying examinations that will ensure the orderly development of the concept of the assistant to the primary care physician.

PHYSICIAN'S AWARD ANNOUNCEMENT—1972 nominations are called for in nominating a physician to receive the "Physician's Award" annually given by the AMA and the President's Committee on Employment of the Handicapped. Persons deemed to have improved and increased employment opportunities for the handicapped and recognition of individual achievement by members of the medical profession are criteria for the award. Chairmen of Governor's Committees and Presidents of State Medical Societies will forward nominees to the President's Committee. Those wishing to place a name in nomination are encouraged to submit information to the ISMS headquarters office.

AGENCY RENAMED—The name of Chicago's official Christmas Seal agency, The Tuberculosis Institute of Chicago and Cook County, has been changed to CHICAGO LUNG ASSOCIATION.

CARVER FAMILY HEALTH CENTER OBSERVES SECOND ANNIVERSARY—Peoria's Carver Family Health Center, where more than 12,000 inner city patients have been treated by volunteer physicians in an experimental health care program, observed its second anniversary in July.

The program originated when members of the Peoria County Medical Society met with community leaders to discuss ways of meeting the medical needs of low income areas of the city. It was recognized that the existing means were inadequate and often inaccessible with most medical care delivered through hospital emergency rooms.

In effect, Peoria's doctors said to the community leaders—"We can supply the medical manpower and are willing to serve the members of this community on a volunteer basis if you will tell us where, when and how."

The leaders responded: Carver Family Health Center became the base within Carver Community Center. Methodist Hospital of Central Illinois helped staff the center with area doctors and gave financial support to cover the cost of hospitalization, laboratory and X-ray diagnostic work. A corps of consultants was developed in the surgical and medical specialties.

Other agencies already active in the community saw the Family Health Center as a method through which more complete and continuing care could be made available to the community. These included the Peoria Health Department and Planned Parenthood Association. Nurses and other health care personnel also became involved.

In its two years of operation, 29 doctors, including some who live and practice in adjacent counties, have participated in primary care delivery in the Center. Every attempt is made for each doctor to continually see his own patients so that an on-going family-doctor relationship is created, exactly as in their own private practice. These doctors have continued to see patients without any financial consideration.

The Center is beginning an educational project as it moves into its third year. Family Practice Residents of the Peoria School of Medicine will work with patients and develop lasting relationships. These residents will spend three years in increasing amounts of time at the Center with the volunteer physicians who will act in a supervisor-faculty role.

The ultimate goal—and perhaps this might be characterized as the Hope of the Carver Family Health Center—would be for each resident to develop a corps of families who would continue with him as he launches into private practice in this community.



Present for the second anniversary observance of the Carver Family Health Center in Peoria were (left to right): Mrs. Irma Davis, director of Carver Community Center; Dr. Paul W. Sunderland, Gibson City, speaker of the House of Delegates of ISMS, which has endorsed the program; Mrs. Sue Bosold, R.N., director, and Dr. Fred Z. White and Dr. Dean R. Bordeaux, medical directors of the Carver Family Health Center. Dr. White and Dr. Bordeaux also are co-directors of the Family Pracice Residency Program, Peoria School of Medicine. In foreground is a sickle cell anemia testing kit.



Business goes on as usual even in the midst of a special occasion—patients wait for turn in examining room at Carver Family Health Center while the experimental health care program's second anniversary is being observed in adjoining meeting hall. Volunteer physicians and other medical personnel, Center administrators, representatives of cooperating agencies and community leaders attended the observance and enjoyed a box chicken dinner.

WORKMENS COMP, OCCUPATIONAL DISEASES PAYMENT RATES INCREASED—Benefit payment rates under the state's workmens compensation and occupational diseases acts increased an average of 20 percent as of June 26. Although legislation authorizing the new rates was signed by the Governor in October 1971, an Illinois Supreme Court ruling was delaying its effective date until now.

MOBLEY NAMED DEPARTMENT CHAIRMAN—Jack E. Mobley, M.D., has been named chairman of the department of urology at Rush-Presbyterian-St. Luke's Medical Center. He is professor of urology at Rush Medical College and attending surgeon at Presbyterian-St. Luke's Hospital. Dr. Mobley was formerly professor and head of the department of urology at the University of Arkansas Medical Center.

IPS PRESIDENT—Dr. Sheppard Kellam, chief psychiatric consultant of the Woodlawn Mental Health Center and University of Chicago staff member, has been installed as president of the Illinois Psychiatric Society. Dr. George H. Pollock, director of the Institute for Psychoanalysis, has been named president-elect. Dr. Francois Alouf, director of education, Department of Psychiatry, Northwestern University, is secretary-treasurer.

RADIOLOGIC TECHNOLOGISTS WEEK—The Illinois State Society of Radiologic Technologists received a State of Illinois Proclamation from Richard B. Ogilvie, Governor of the State of Illinois, proclaiming September 17-24, 1972, RADIOLOGIC TECHNOLOGISTS WEEK in Illinois.

NEW STATE EPIDEMIOLOGIST—Byron J. Francis, M. D., has been appointed as the new state epidemiologist. Dr. Francis comes to Illinois from the State of Washington where he served four years as head of the Epidemiology Section of the State Department of Social and Health Services. He was born in Chicago. His family moved to Seattle, Washington, when he was six years old but he returned to Illinois to attend college. He received his A. B. degree from the University of Chicago in 1950 and his M. D. from the University of Chicago School of Medicine in 1956. He received his M.P.H. degree in 1965 from the School of Public Health of the University of Minnesota.

PHYSICIANS IN THE NEWS—The Elgin Kiwanis Club recently gathered to honor Francis R. Towner, M.D., as the oldest active past-president of the group. Dr. Towner, who practiced in Elgin for over 44 years, will soon be moving to Florida.

A new arrival in Kewanee is Dr. David Stearns. Dr. Stearns formerly practiced in Nevada, Iowa, and has moved to Kewanee to set up general practice.

Three Peoria physicians have been named to staff positions at the new Peoria Medical School, all in the Department of OB-GYN. They are Dr. Peter J. Couri, Dr. Ralph Gibson, and Dr. William S. Miller. The new school also recently received a federal grant of $38,000 for its library.

Kane County Medical Society recently honored Dr. Kenneth Bulley of Aurora. Dr. Bulley, 69, is in charge of the Kane Co. TB Clinic, and prior to 1969 was director of Aurora's Springbrook Sanitarium. He is retiring after 36 years practice.

Charles P. McCartney, M.D., has been elected president-elect of the Chicago Medical Society. Dr. McCartney, formerly CMS secretary, is clinical professor of OB-GYN at the Abraham Lincoln School of Medicine, University of Illinois.

Recently appointed visiting lecturer at the Univ. of Minnesota was Bertram Moss, M.D. Dr. Moss is Clinical Director of the Division of Gerontology and Assistant Professor of Medicine, the Chicago Medical School, as well as Executive Director of the Park View Home, Chicago.

Dr. Clifford W. Gurney has been appointed Deputy Dean of the Division of the Biological Sciences and The Pritzker School of Medicine and Deputy Dean for the Clinical Sciences and Professor in the Division of the Biological Sciences and the Department of Medicine at The University of Chicago. Dr. Gurney, 48, has been Chairman of the Department of Medicine at the University of Kansas School of Medicine, Kansas City, Kansas.

The University of Health Sciences/The Chicago Medical School has named two of its faculty members distinguished professors. Israel Davidsohn, M.D., in pathology, and Aldo Luisada, M.D., in medicine and physiology have received special recognition.

The American Association for the Study of Headache has elected Seymour Diamond, M.D. as President of the Association for the term of 1972-1973. "Headache-A Symptom of Depression," an exhibit by Seymour Diamond, M.D. and Bernard J. Baltes, M.D., Ph.D. of the Chicago Medical School, won the award of Honorable Mention in the Section of Psychiatry at the American Medical Association meeting held in San Francisco.

Dover Roth, M.D. is the new director of Forest Hospital's Young Adult program, aimed at men and women 18 to 25 years of age. It is a specialized psychiatric program which enables treatment especially designed to the special needs unique to this age group. Admission to the program is at the request of individual attending psychiatrists. Forest is in Des Plaines.

Medical Exhibitors Honor CMS Exhibits Director



Recipient of the first Certificate of Recognition ever awarded by the Medical Exhibitors Association was John A. Venator, Director of Exhibits of the Chicago Medical Society. The award, presented at the recently concluded AMA Convention, was given in recognition of Mr. Venator's "significant contribution to the improvement of medical meetings." In the photo above, Venator, right, is shown being presented the certificate by William H. Buch, president, Medical Exhibitors Association (left) while Dr. George F. Lull, CMS Medical Director, looks on.



New President of CMS

Dr. Charles P. McCartney recently was elected president of the Chicago Medical Society. For the past several years Dr. McCartney has served as Secretary of the organization. He is a specialist in OB-GYN.

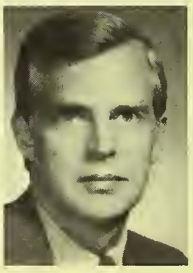
Michael Reese Alumni Association Officers

Dr. Saul Haskell (top) and Dr. Perry Rudich (bottom) were elected President and Secretary-Treasurer respectively of the Michael Reese Hospital and Medical Center Alumni Association. Dr. Haskell is an attending physician in Orthopedics at Michael Reese. He was an undergraduate at Vanderbilt and took his internship and residency at Reese. He is Board certified. Dr. Rudich is an associate attending physician in the Reeses Department of Diagnostic Radiology. He received his M.D. from the University of Illinois, and took his radiology residency at Reese.





New Officers of Committee on Handicapped



Governor Richard B. Ogilvie recently appointed Dr. Henry B. Betts, M.D., (left) Chairman, and Harold V. Hopkins, Jr., Executive Director of the Illinois Governor's Committee on Employment of the Handicapped. The committee promotes agencies concerned with the development of equal opportunities and the elimination of environmental barriers which limit the physically and mentally handicapped person. Dr. Betts, Vice President-Medical Director and a Director of the Rehabilitation Institute of Chicago, is recognized as one of the nation's leaders in the field of rehabilitation medicine.

SUPPORT IMPAC

THE BODY POLITIC

In pursuit of medical knowledge, we were exposed to and studied the anatomy of the human body. We learned the endoskeleton consists of numerous bones and forms a supporting framework.

As citizen-physicians we are now confronted with another endoskeleton, "The Body Politic." This body also has bones, however disjointed, which must be studied and understood if we are to learn our anatomy. This new anatomical monstrosity of bones also has related systems more complex in nature and frustrating in application but offering a lesson and a challenge that every physician must accept.

The Back Bone

Most of us refer to the back bone as the vertebral column, but to politicians and the body politic it has a different meaning. Perhaps the back bone, or lack of, can be interpreted as people, voters, party workers or members of political action groups (AMPAC-IMPAC). Some refer to the back bone as the determination and strength to fight for your philosophic convention —yes, sometimes your life!

Knuckle Bones

Knuckle bones are carpal and metacarpal bones in our hands, not heads; politicians often confuse these in referring to physicians.

Political knuckle bones are the hard bones that win victories. They are identified with political action, accomplishment of purpose and willingness of spirit.

Let us not knuckle-under the power of the mailed fist, but knuckle-down to bruising our knuckles instead of our egos. Be politically active in the party of your choice. Become identified with Illinois Medical Political Action Committee.

Head Bones

Head bones, the skull, protect the brain from physical injury—not knowledge. Perhaps we physicians have developed hypertrophy of our skulls through over-protection and rejection of other people's ideas resulting in atrophy of our brains. Our head bones have been described as bone head, thick head, pig head, pea head, and no head at all!

That, within our head bones, has been more highly educated and stimulated than most people; however, in this quest to become a doctor we have become narrow-minded and opinionated, confining our thinking to the endoskeleton of the human body. Why not learn the anatomy of the political body—it may prove rewarding.

The Tail Bone

The coccyx or tail bone seems to be the most used bone of the political body. A bone often resorted to as an excuse for "I don't want to be involved in politics," "too busy with my practice," "What's the use," or "costs too much, $25."

The Body Politic is often referred to as a pain in my tail bone—sometimes it is—but do we sit on a pain and suffer its discomfort or do we try to find a remedy? Have you ever tried the prescription called **IMPAC-AMPAC?**

Wish Bone

The clavicle, used for wishful thinking, allows an escape from the reality of life and is psychologically not anatomically connected to the over-used tail bone. It is often substituted for the back bone, knuckle bones, and head bone.

It's up to YOU

Let's face it, our political problems are not going away, but are being compounded at an alarming rate. Election year 1972 will be crucial for organized medicine. Undoubtedly, a national health care plan will be enacted in the 93rd Congress.

IMPAC-AMPAC has become effectively involved in the Body Politic, but your help is needed.

(With gratitude to Montana Medical Association)


When irritable colon feels like this

...in the presence of spasm or hypermotility, gas distention and discomfort, **KINESED®** provides more complete relief:

- ☐ **belladonna alkaloids—for the hyperactive bowel**
- ☐ **simethicone—for accompanying distention and pain due to gas**
- ☐ **phenobarbital—for associated anxiety and tension**

Contraindications: Hypersensitivity to barbiturates or belladonna alkaloids, glaucoma, advanced renal or hepatic disease.
Precautions: Administer with caution to patients with incipient glaucoma, bladder neck obstruction or urinary bladder atony. Prolonged use of barbiturates may be habit-forming.
Side effects: Blurred vision, dry mouth, dysuria, and other atropine-like side effects may occur at high doses, but are only rarely noted at recommended dosages.
Dosage: *Adults:* One or two tablets three or four times daily. Dosage can be adjusted depending on diagnosis and severity of symptoms.

Children 2 to 12 years: One-half or one tablet three or four times daily. Tablets may be chewed or swallowed with liquids.

STUART PHARMACEUTICALS | Division of ICI America Inc. | Wilmington, Del. 19899 | Pasadena, Calif. 91109

(from the Greek **kinetikos**,
to move,
and the Latin **sedatus**,
to calm)

KINESED®

antispasmodic/sedative/antiflatulent

Each *chewable tablet* contains: 16 mg. phenobarbital (warning: may be habit-forming); 0.1 mg. hyoscyamine sulfate; 0.02 mg. atropine sulfate; 0.007 mg. scopolamine hydrobromide; 40 mg. simethicone.

Chuckwalla (*Sauromalus obesus*):
This southwestern desert lizard seeks
shelter in crevices of rocks.
When attempts are made to probe him
from his niche, he gulps air
until his torso is distended up to
sixty per cent over its normal size...
thus wedging himself tightly
in place and preventing capture.

report

a service of the american association of medical assistants, illinois society

STOP -- LISTEN -- LEARN

A A M A , ILLINOIS SOCIETY

EDUCATIONAL SYMPOSIUM

SUNDAY

SEPTEMBER 17, 1972

SHERATON-JOLIET MOTOR INN

250 N. Ottawa Street

Joliet, Illinois

REGISTRATION	8:00 to 9:00 a.m.
CONTINENTAL BREAKFAST	8:00 to 9:00 a.m.
MORNING SESSION	Welcome—Merle Otto, M.D., President Will-Grundy Medical Society
LUNCHEON	"Effective Listening"
AFTERNOON SESSION	"Lamaze" Natural Childbirth Mrs. George Honiotes
	"Love Pollution"—Guy Pandola, M.D.
	"Thread of Life"—film on Genetics

"LET US ENTERTAIN YOU"

Plan to arrive on Saturday, September 16, 1972 to enjoy an evening of fun with us.

Registration fee: $8.00 (includes: breakfast, luncheon, educational materials)

Mail to: Mrs. Fran Wroblewski, 2101 N. Center Street, Joliet, Illinois.

NAME ADDRESS

PHONE CHAPTER OR COUNTY

DEADLINE DATE: September 10, 1972 MEMBER NON-MEMBER.....

ANOTHER ISMS MEMBERSHIP PRIVILEGE
LOW-COST GROUP INSURANCE

GROUP
DISABILITY PLAN

- NEW—Guaranteed renewable feature
- Sickness benefits to age 65
- Up to $250.00 weekly benefits

(PROTECT YOUR INCOME AND SECURITY)

GROUP
SUPER MAJOR MEDICAL PLAN

- Up to $50.00 daily room and board
- Up to $25,000 for each accident or sickness
- In hospital and out of hospital expenses

(TRULY CATASTROPHIC PROTECTION)

FOR INFORMATION, ASSISTANCE & DETAILS CONTACT:
Administrators:
PARKER, ALESHIRE & COMPANY
ESTABLISHED 1901
Insurance

9933 N. Lawler Avenue
Skokie, Illinois 60076
Phone: 312-679-1000

What Goes On

(Continued from page 134)

and Infectious Agents, Man and Diseases of Modern Society and Advances in Internal Medicine. The Congress will also have scientific and technical exhibits. For information contact: Thomas A. Warthin, M.D., General Chairman, XII International Congress of Internal Medicine, 4200 Pine Street, Philadelphia, Pennsylvania.

Sheraton Boston Hotel, Boston, Mass.

September 6-8—The Division of Clinical Oncology of the University of Wisconsin

10th Cancer Chemotherapy Conference

The conference is open to all United States Physicians interested in cancer chemotherapy. It will review and present a forward look at anti-cancer therapy of solid tumors and leukemias as well as the role of radiotherapy immunology and virology in the treatment of cancer. For information contact: G. Ramirez, M.D., University Hospitals, 1300 University Avenue, Madison, Wisconsin 53706

Park Motor Inn, Madison, Wisconsin

September 10—The American Society for Gastrointestinal Endoscopy

Postgraduate Course—Clinical Gastroenterology

Contact: Vernon M. Smith, M.D., Director, 301 St. Paul Place, Baltimore, Maryland 21202

Castle Harbour Hotel, Bermuda

September 11-12—American Medical Association

The 32nd Annual AMA Congress on Occupational Health

The AMA congress will include Multiphasic Health Testing In Industry Symposium, Nuclear Reactors—Employee and Community Safety Symposium, Symposium on Aerospace Medicine, Group Practice in Occupational Medicine Symposium and a Lecture-Demonstration on Physical Diagnosis for Emotional Disorders. No Registration Fee.
Contact: American Medical Association, 535 N. Dearborn, Chicago 60610

The Drake Hotel, Chicago

September 11-15—Childrens Hospital Medical Center

Pediatrics

This is an intensive five-day course with a large faculty which annually focuses its attention upon recent advances and reviews current practices in pediatrics. The curriculum reflects this attention and is oriented to the problems faced by those physicians who care for and about children. Emphasis is placed upon progress in the sciences and the specialties which relate to pediatrics, and their practical application to the understanding of normal development, as well as to the diseases and disabilities of the fetus, infant, child and adolescent.
Registration Fee: $200
Contact: Associate Dean, Department of Continuing Education, Harvard Medical School, 25 Shattuck Street, Boston, Massachusetts 02115

The Children's Hospital Medical Center, Boston, Mass.

(Continued on page 161)

Air Traffic Controllers Syndrome

(Continued from page 115)

3. Monson, R. R.: McMahon, B. "Peptic Ulcer in Massachusetts Physicians," *New England J Med* 281: 11-5, July 3, 1969.
4. Pell, S. and D'Alonzo, C.A.: "Prevalence of Chronic Disease Among Problem Drinkers," *Arch Environ Health* 16: 679-684, May 1969.
5. Brooks, F. P.: "Stress Ulcer, Etiology, Diagnosis, and Treatment," *Med Clin N Amer* 50, 1447-1455, Sept. 1966.
6. Roseman, R.H., Friedman, M., and Straus, R.: "Coronary Heart Disease in the Western Collaborative Group Study. A Follow Up Experience of Two Years," *JAMA* 195: 86-92, Jan. 10, 1966.
7. Blumenthal, I.S.: "Digestive Disease as a National Problem, 3: Social Cost of Peptic Ulcer," *Gastroenterology* 54: 86-92, Jan. 1968.
8. Gremm, R. L.: "Peptic Ulcer in Airline Stewards," *Aerospace Med* 40: 890-893, Aug. 1969.
9. Weir, R.D., and Backett, E.M.: "Studies of the Epidemiology of Peptic Ulcer in a Rural Community: Prevalence and Natural History of Dyspepsia and Peptic Ulcer," *Gut* 9: 75-83, Feb. 1968.
10. Friedman, E.H., and Hellerstein, H.K.: *Psychomatic Med* 30: 72-86, Jan.-Feb. 1968.
11. U.S. Dept. of H.E.W.: "Chronic Conditions Causing Activity Limitation, US July 1963-June 1965." *Vital and Health Statistics*, Feb. 1969. National Center for Health Statistics. Series 10, No. 5.

Maternal Death Study No. 6

(Continued from page 120)

financially stressed, pregnant against their desires with no recourse but the criminal abortionist, frightened and ignorant and in an attempt to protect themselves and the abortionist, they refuse to admit that they have been aborted; or, as was the case here, even to be examined. One can scarcely censure the physician who refused to accept management of an uncooperative patient. Yet, had better communications been established, the patient admitted and treated earlier, the outcome might have been different.

The use of a pack in an obviously infected uterus seems fraught with danger. We seem to have forgotten the effect of warm water intrauterine lavage as advocated by Bozeman and later T. K. Brown which will control many instances of this type of bleeding. Since the offending organism is almost always an anaerobe or a facultative anaerobe, packing seems illogical; and in a patient as desperately ill as this lady was at the time of her admission, may have contributed to the advancement of her infection. **While your committee felt that there were preventable factors both as relates to the patient and the physician, the question was raised as to whether or not society itself was partially responsible.**

View Box

(Continued from page 130)

DIAGNOSIS: *Caustic esophagitis*

Caustic esophagitis resulting from lye ingestion. An alkali affects the esophagus by causing liquefaction necrosis, but is neutralized by stomach acids and thus has no great effect on the stomach. However, the patient that swallows concentrated acid develops antral and pyloric stenosis, as the stomach undergoes coagulation necrosis and severe spasm, in turn favoring the retention of the chemical and causing further damage producing a defect which has the appearance of a stenosing carcinoma. The extent or severity of the lesion depends on the quality and concentration of the liquid swallowed. The age of the patient and initial treatment also are important in the prognosis of this type of esophagitis.

In the acute first stage of necrosis, radiologic investigation with barium is rarely performed. Roentgenograms of a patient with acute esophagitis will usually show a clear and constant image of ulceration by about the fifth day after ingestion.

In the following weeks, before organized stenosis, an intermediate stage may exist during which stiffness, rather than narrowing of the segment, may be observed radiologically; outlines are set and are unchanged by filling or peristalsis. These signs are frequently caused by an early periesophagitis.

It is at the stage of fibrosis or retractible sclerosis, with alteration of the course and caliber of the esophagus, that the radiographic examination is usually performed. The form of narrowing varies; it may be annular, or it may resemble a rosary or an hourglass. The orifices are often eccentric. In the thoracic esophagus, the narrowing is usually straight, tubelike, rigid, smooth, and lacking mucosal pattern. The transition between the stenosis and the adjacent segment is gradually progressive and funnel-like.

Further evolution of the stenosis is usually slow and unrelentingly progressive. Despite therapeutic efforts the long-term prognosis remains poor. Eventual development of cancer also is possible.

We can do much more together!

★

Specialized Service

IN

PROFESSIONAL LIABILITY INSURANCE

is a high mark of distinction

THE

MEDICAL PROTECTIVE COMPANY

FORT WAYNE, INDIANA

Professional Protection Exclusively since 1899

CHICAGO AREA OFFICE: T. J. Pandak, J. C. Kunches, and L. R. Gannan, Representatives
T. J. Haehn, Consultant
815 Commerce Drive, Suite 102, Oak Brook, Illinais 60521 (312) 325-7314
SPRINGFIELD OFFICE: W. J. Nattermann, Representative
426½ Sauth Fifth Street, Springfield 62701 (217) 544-2251

EKG of the Month

(Continued from page 135)

Answers:

A3, B4. The electrocardiogram shows intermittent or rate-related left bundle branch block. It is an example of the critical rate phenomenon where a very slight increase in heart rate results in bundle branch block. It may be caused by deep inspiraton, carotid sinus pressure, or the Valsalva maneveur. Although left bundle branch block is not normal, no specific treatment is indicated and the patients are generally asymptomatic from a cardiac viewpoint.

Plans are underway for the annual Leadership Conference of the Illinois State Medical Society. Problems of malpractice insurance, the increasing numbers of claims, and alternative methods with possible resolutions to this problem will be the chief topic. Watch for further detailed information.

ASSOCIATE MEDICAL DIRECTOR

Inland Steel Co., Indiana Harbar Works, one of Chicagaland's largest manufacturing camplexes is seeking an Associate Medical Director.

Our Medical Department is a fully staffed camplex including an X-Ray, Labaratory, and an accupatianal hygiene division.

There is a full range of medical activities including traumatic, pre-placement and consultative services in a plant whose papulatian exceeds 20,000. Salary is negotiable with an outstanding no-cost benefit package included.

Reply ta:

Mr. C. M. MITCHELL
Assistant Director, Persannel

INLAND STEEL CO.
3210 Watling Street East Chicago, Ind. 46312
Equal appartunity emplayer

PULSE ●●● of the doctor's wife

Mrs. Robert Hart, Pulse Editor

From the President's desk . . .

No doubt about it . . . the opening ceremonies of the AMA House of Delegates honoring the 50th Anniversary of the WA/AMA was impressive and a special tribute.

A slide presentation "Beyond the Window," based on a script written by Mrs. Harlan English and Mrs. Rodney Stoltz, projected a kaleidoscopic picture of the growth and development of the Auxiliary. The production combined images on three-panels of film strips, photo montage (including the 48 national presidents), plus original art work—combined with live action, narration, and a full orchestra. It was directed by Eleanor Chappell and featured Auxiliary members teamed with professional actresses and actors.

The conference on Medicine and Religion drew an overflow crowd with William H. Masters, M.D. and Virginia Johnson Masters, who predicted that as the public increasingly becomes more comfortable with the subject of sexual function (an integral part of every man and woman's physical means of communication), those professions dealing with problems of sexual interaction will be swamped by the legitimate demands of a long-suffering society for relief from the marital destructive influence of sexual inadequacy.

Topics covered during the day long session on the Quality of Life were drugs, V.D., and violence . . . three of the areas that greatly alter the life of adolescents. San Francisco area youths (Caucasians, Negroes, Chinese) who are members of national commissions on youth problems made a presentation stressing youths' need for a sense of identity and a need to play an important role in society. They spoke of the need to develop adequate community programs and of their frustrations when things are sometimes put forth, but then nothing gets done. This panel looked upon the AMA session as a positive start. One youth also asked physicians to become more involved with their own families ". . . they should be the most important people to you!"

I leave you with this thought . . . It is YOU, the people, not necessarily just the programs, who are the beginning answer to solving such problems as drug abuse, V.D., violence, and our multitude of socio-economic problems. So, please, become involved . . . get to know each other, communicate with your National, State, and County Chairmen, who are willing and eager to assist and guide you on your projects. And let us hear from you . . . of your thoughts, needs, and accomplishments.

State	Membership	Dues	State	Nat'l
Illinois	2857	$8.00	$4.00	$4.00
Iowa	1184	7.00	3.00	4.00
Kentucky	1150	8.00	4.00	4.00
Michigan	3350	6.00	2.00	4.00
Minnesota	2300	5.00	1.00	4.00
Missouri	1625	8.00	4.00	4.00
Wisconsin	2050	6.00	2.00	4.00

Above is a brief chart showing the number of members in surrounding state auxiliaries and a breakdown of dues disbursement for comparative purposes with Illinois.

Chicago Medical Auxiliary took part with 27 other church and charity groups in Park Forest Plaza to create an international setting of 28 colorfully decorated booths of different countries and cultures for fun and shopping for homemade goods and apparel. Proceeds were expected to reach $25 for donation to community services and philanthropic projects.

Linia Martinucci

President

District Meeting Dates

September 12—District Host Cook County
Combined Districts 1,2,3,11
October 17—District Host—Peoria County
Combined Districts 4,5,6,7,8,
November 9—District Host—St. Clair-Belleville
Combined Districts 9,10

Convention Date

March 25-28, 1973—Conrad Hilton, Chicago

Illinois auxiliary members participate in first AMA-WA/AMA conference on health education for representatives of national organizations.

Education is the "key to health," and nine Illinois Auxiliary members participated in the AMA—Auxiliary Health Education Conference to help find how health education can improve the quality of life for everyone. The Conference, held April 26-28, 1972, at the Drake Hotel, Chicago, brought together representatives of more than seventy organizations, ranging from the National Council on Aging to the Campfire Girls. The scope of health education goes beyond knowledge about health—to what people feel and do about it. It includes human attitudes, values, and life styles . . . which help determine human behavior.

Martin Agronsky, journalist for the Public Broadcasting System, said in his keynote address "Most Americans are confused, lonely, alienated. We all dance on the edge of a volcano." Dr. Niles Anne Newton, Northwestern University Psychologist told the Conference "many women do not have meaningful work anymore, and this is one of the reasons they have so much depression, sense of futility, and narcissistic attention to self. A federal study found that 21% of American housewives surveyed reported they were on the verge of a nervous breakdown."

Dr. Robert Kaplin, Ohio State University Professor of Health Education said "health education is where it's at. And unless we take action now, it will come back to haunt us." Mrs. Julie Nixon Eisenhower addressed the Conference and told them "I could not agree more with the goal of this Health Education Conference: To establish health education programs on every level in every community across the country. Both the education and the medical and health professionals will find their work far easier and their success far greater with combined efforts to create an awareness of health problems across the nation. Volunteerism in partnership with government can stimulate sensitivity and understanding of the physical, mental, and emotional health needs of people. In your hands rests the challenge that touches the life of every American. In accepting the challenge of health education you will do a great service to our nation."

Mrs. Irvin E. Hendryson, Committee Member stressed, "we must seek the positive state of a healthy mind and a healthy body in a healthy environment." Other speakers included Max H. Parrott, M.D., Chairman of AMA Board of Trustees, who termed health a "common cause," with medicine playing a major role but requiring participation from everyone." Mrs. G. Prentiss Lee, Auxiliary President, urged the conferees to start cooperative action programs in their states and in their communities. Emphasizing individual responsibility, "The medical family can't do it alone . . . every individual's concern for his own health is a vital force in keeping the nation healthy." Such community cooperative action can aid the many current programs and assist with needed efforts in needy areas so that together we can bring about a turning point in life for the present and future generations.

Mrs. Wendall F. Foller, Chairman
AMA-WA/AMA Health Education
Conference



Meeting together at the Conference on Health Education were (from left) Mrs. A. Martinucci, Mrs. J. Ovitz, Mrs. H. English, Mrs. W. Bornemeier, John E. Egdorf, Mrs. W. Scrivner, Mrs. R. Hartman, Mrs. M. Spellberg, Mrs. E. Vickery and Mrs. W. Roller.

Auxilians Honored

It was a proud day for the Illinois Delegation to have our own Mrs. Willard Scrivner (East St. Louis) installed as President-Elect of the WA/AMA. Belleville-St. Clair Auxiliary presented her with 50 roses and the State Auxiliary presented her with a rose corsage and a gold jade charm denoting San Francisco. Also honored were Mrs. Wendell Roller (Monmouth) as Regional Vice-President; Mrs. Sherman Arnold (Flossmoor) as regional Vice-President of AMA-ERF; and Mrs. Harlan English (Danville) as past national President. Congratulations to them all . . . we're proud of you.

Aspects of Nutritional Status of Preschool Children in the United States, 1968-1970

By George M. Owen, M.D./Columbus, Ohio

For purposes of this presentation, I have abstracted material from our Preschool Nutrition Survey (PNS) which was based on a cross-sectional sample of the U.S. population[1] and from the 10-State Nutrition Survey (TSNS) which was based primarily on lower income population groups in 10 states and New York City[2].

In the PNS, 3,500 children between 12 and 72 months of age from approximately 2,500 families were interviewed in 74 primary sample units in 36 states and the District of Columbia. We have used Warner's Index Stratification Characteristics (ISC) which is based on ratings of occupation, source of income, dwelling type and dwelling area, to subdivide our study population[4]. Each of the four status characteristics were rated for each family on a seven-point scale extending from 7 ("very low") to 1 ("very high"). The ratings on the separate status characteristics were combined into a single numerical index by assigning to each one a weight and securing a weighted total of the separate ratings. The ISC sums thus obtained were then converted into a prescribed rank extending from I-to-V.

The preschool population we studied was distributed in Ranks I-to-IV since there were no families whose ISC sum placed them in the highest Warner Rank (V).

Clinical

Overall, some 40 children in the PNS manifested clinical signs suggestive of nutritional deficiency disease or of general undernutrition with percentages of children in individual Warner Ranks varying from 4% in Rank I to 1% in Rank IV. Regressions of height (cm) on age (months) were computed using data on all children whose birth weights were equal to or greater than 2,500 grams. There appeared to be a direct positive correlation between socioeconomic status and stature.

Dietary

It was apparent that a greater proportion of children of lower socioeconomic status (Warner Rank I) had dietary intakes of calories and of certain nutrients below arbitrarily-selected levels, some of which have been used to differentiate acceptability and unacceptability[2,3], than was true for children of higher socioeconomic status (Warner Rank II-IV).

Biochemical

Similarly, using arbitrarily-selected criteria for definition of acceptability and unacceptability of biochemical indices, a greater proportion of lower ranked children had unacceptable biochemical indices than was true of higher ranked children. Preschool children in the TSNS had biochemical indices similar to but often worse than those of Warner Rank I children in PNS, no doubt reflecting the relatively greater proportion of very poor children in TSNS than in PNS.

Comment

In general, there appears to be a positive direct correlation between socioeconomic status estimated by use of Warner's ISC and nutritional status of preschool children in the U.S. Use of this sociological tool in nutrition studies will be presented and discussed in some detail elsewhere[5,6]. ◄

This is one of a series of papers presented at the Fourth Symposium on Nutrition and Food Technology, March 29, 1972, Lake Shore Club, Chicago. The symposium was co-sponsored by the Illinois State Medical Society, the Chicago Nutrition Association, and the Institute of Food Technologists-Chicago Chapter.

This paper was supported by Grant MC—R=390050—06—0 from Maternal and Child Health Services, Department of Health, Education and Welfare, Health Services and Mental Health Administration, Washington, D.C.

Geargе M. Owen, M.D., is Head of the Department af Pediatrics and Prafessar af Pediatrics, Ohio State University Callege af Medicine and of the Children's Hospital Research Foundation, Columbus. He is well known for his comprehensive surveys of the nutrition status af segments of the population in various parts af the United States.

Table 1

Some demographic characteristics of participants in Preschool Nutrition Survey

	WARNER RANK				
	I	II	III	IV	V
Social Class Equivalents	Lower-Lower	Upper Lower	Lower-Middle	Upper-Middle	Upper
Warner ISC Sum	84-67	66-52	51-38	37-23	22-12
Families (No.)	392	650	384	266	0
Median Income ($)	3,500	6,500	9,500	13,000	—
Preschool Children (No.)					
12-23 months	120	261	195	56	—
24-47 months	263	546	441	149	—
48-71 months	233	568	422	169	—

Table 2

Percentage distribution of heights on children in Preschool Nutrition Survey

	PERCENTILES					
Warner Rank	Less than 10th	10th thru 24th	25th thru 49th	50th thru 74th	75th thru 89th	90th and above
I	10*	16	22	25	12	12
II	8	12	24	25	18	10
III	5	12	23	28	17	12
IV	5	11	21	27	22	12

* (Note that figures in this column refer to the proportion of the children in each Rank whose heights were *less* than 10th percentile. Since the percentiles were derived from data on children in this study, 10% of heights were *equal to or less than* 10th percentile.

Table 3

Percentage of children in Preschool Nutrition Survey with daily intakes of calories and of certain nutrients below arbitrary levels.

	WARNER RANK	
	I	II-IV
Calories (Kcal/kg)		
< 60	14	4
< 70	28	12
< 80	42	29
Protein (gm/kg)		
< 1.5	3	< 1
< 2.0	11	3
< 2.5	23	11
Calcium (mg)		
< 200	6	1
< 400	23	8
< 600	47	25
Vitamin A (I.U.)		
< 1000	12	2
< 1500	17	6
< 2000	30	13
Vitamin C (mg)		
< 8	5	< 1
< 15	10	2
< 30	30	15

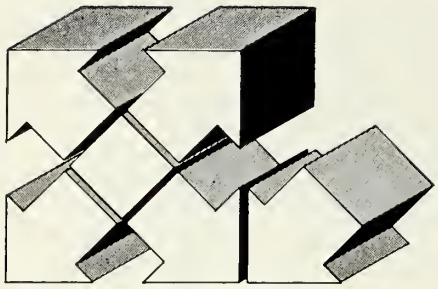
Table 4

Percentage of children in PNS and in TSNS with biochemical indices below arbitrary levels.

	PNS WARNER RANKS		
	TSNS	I	II-IV
Hemoglobin (gm/100 ml)			
< 10	10	4	1
< 11	23	12	5
Plasma Albumin (gm/100 ml)			
< 3.0	2	0	0
< 3.5	9	10	7
Plasma Vitamin A (ug/100 ml)			
< 10	4	0	0
< 20	20	5	1
Plasma Vitamin C (mg/100 ml)			
< 0.2	6	14	3
< 0.3	16	26	5

References

1. Owen GM, Lubin AH, Garry PJ: "Preschool children in the United States: Who has iron deficiency?" *J. Pediat* 79:563-568, 1971.
2. Ten-State Nutrition Survey in the United States, 1968-1970: Preliminary Report to Congress, April, 1971.
3. Trowbridge FL: Review of the findings of the Ten-State Nutrition Survey.
4. Warner WL: Social Class In America, New York: Harper & Row, 1960.
5. Owen GM, Kram KM, Garry PJ, Lubin AH, Lowe JE: "A study of nutritional status of preschool children in the United States, 1968-1970" (in preparation).
6. Lowe JE: "Influence of cultural and socioeconomic factors on nutritional status of preschool children" (in preparation).



trauma center

A New Health Professional: The Trauma Coordinator

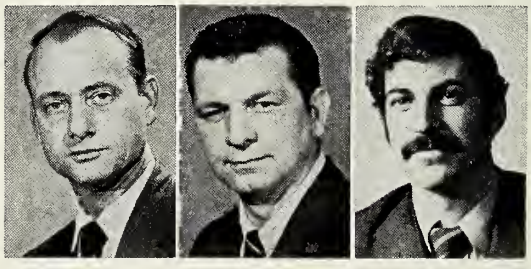
By Kenneth D. Mains, USN/FLT RES, David R. Boyd, M.D.C.M., and Bruce A. Flashner, M.D./Chicago

The success of the Illinois Statewide Trauma Program has been due to many factors. One of the most important has been the utilization of existing and available resources for the optimal care of the critically injured. A previously untapped resource has been made available to the State of Illinois because of the Executive Office's initiative to hire competent and trained military personnel for civilian jobs within state government. This initiative has provided the necessary qualified personnel to the Illinois Department of Public Health for the major task of renovating the Emergency Health System. These expert allied health professionals—the Trauma Coordinators—have many years of military training and experience in casualty care and transportation and have become an essential mainstay of the Illinois Statewide Trauma Program.

Within each trauma center in the statewide system, a team has been developed. Integral to this team are the hospital's attending physicians and medical staff. With them rests ultimate responsibility for primary treatment and transfer decisions. Supporting this staff is the Trauma Coordinator who is under the direction and supervision of the physician. The Trauma Coordinator handles a wide variety of emergency room problems in a sophisticated manner. He is involved in the training and supervision of ambulance personnel and is currently helping to integrate and coordinate the communication and transportation components of the emergency care delivery system.

The Trauma Coordinator's basic responsibilities include:

1. **Data Collection:** By utilizing the computerized Trauma Registry, he gathers, monitors, and transmits medical data.
2. **Education:** He assists the training of paramedical personnel, technicians and ambulance attendants in basic resuscitation and initial care techniques; coordinates more specialized physician educational programs in collaboration



KENNETH D. MAINS (left) is administrator of the Division of Emergency Medical Services and Highway Safety, Illinois Department of Public Health. Mr. Mains joined IDPH in June, 1971, after serving 24 years in the U.S. Navy where he gained experience in medical evacuation of the injured.

DAVID R. BOYD, M.D.C.M., (center) is chief of the Division of Emergency Medical Services and Highway Safety, Illinois Department of Public Health, and assistant professor of surgery at the Abraham Lincoln School of Medicine.

BRUCE A. FLASHNER, M.D., (right) is deputy director of the Illinois Department of Public Health and medical director of the Illinois Department of Public Aid. He is also an assistant professor of health care planning at Southern Illinois University School of Medicine.

with local medical educational institutions; and cooperates with local health educators who desire to utilize the trauma center for clinical training of medical and paramedical students.

3. **Communications and Transportation:** He is presently integrating his center into the statewide trauma system by using computerized information systems, radio, ambulance and helicopter services.
4. **Biomedical Equipment Maintenance:** He is skilled in the use and maintenance of instruments such as monitors, defibrillators, etc.
5. **Community Relations:** He is encouraging and working with community groups to establish emergency Service Councils.

His activities relate to those of the total community. It is necessary for the hospital staff and Trauma Coordinator to understand this and to share their respective responsibilities. Out of such an understanding, the trauma team relates effectively and patient care is improved within the statewide system.

The Potential Loss to Illinois

Since commencement of the President's de-escalation in Vietnam, in the late 1960's, the Armed Forces have been separating approximately 30,000 to 35,000 highly trained and qualified hospital corpsmen annually, only a fraction of which have found their way into the civilian health care field. This is due primarily to the paucity of positions available to them. Many have had to accept low paying jobs as ambulance attendants and ward orderlies. Because of this, they have sought employment in other areas. Hundreds of senior men, Chief Petty Officers and Non-Commissioned Officers, have held positions as independent medical officers (assistant administrators, supply chiefs), accountable for hundreds of thousands of the taxpayer's dollars. They have performed as supervisors of departments of pharmacy and radiology, laboratories, emergency rooms and operating services, and are now finding it impossible to enter the civilian medical system at a comparable level.

In the Navy alone, hospital corpsmen, upon becoming qualified for independent duty aboard a naval combat ship or ancillary type vessel upon which the crew may count four to five hundred men, have completed approximately seventy weeks of schooling and have up to twelve years

(Continued on page 160)

PHYSICIANS

TWO INTERESTING
FULL-TIME or PART-TIME
POSITIONS

●

A well-known, research-oriented institution in Western suburban Chicago offers excellent arrangements, including convenient, mutually agreeable hours.

One position involves the practice of standard office medicine, conducting health examinations for present and prospective employees in our well-equipped clinic.
The second entails the medical study of patients who have been exposed to radiation or radioactive substances, and includes investigating and verifying causes of death and pathological conditions, devising protocols for medical examinations and autopsies and/or performing or supervising this work, and participating in research studies to determine dose-effect relationships.

● ● ● ● ● ●

Reply in confidence, including your curriculum vitae, availability and salary requirements to Mr. Ronald A. Johns, Professional Placement, Argonne National Laboratory, 9700 S. Cass Avenue, Argonne, Ill. 60439.

U of C-AUA-USAEC

ARGONNE NATIONAL LABORATORY

An equal opportunity employer M/F

Sickle Cell Screening

(Continued from page 127)

10. Kettman, M.S., Nishikawa, A. H., Morita, R. Y., et al: Effect of hydrostatic pressure on the aggregation reaction of poly-L-valyl-ribonuclease. Biochem Biophys Res Commun 22:262-67, 1966.
11. Kauzmann, W., Eyring, H.: The effect of the rotation of groups about bonds on optical rotatory power. *J Chem Phys* 9:41-53, 1941.
12. Yakulis, V. J., Heller, P.: An elution test for the visualization of hemoglobin S in blood smears. *Blood* 24:198-201, 1964.

Trauma Center

(Continued from page 159)

of clinical experience. This background includes the basic hospital corps, advance hospital corps, field medical, medical administrative, and numerous other schools. The entire expense of this training has amounted to $50,000 to $60,00 per man.

The Governor of Illinois has taken the first step to tap this excellent resource of trained personnel for the Statewide Trauma Program. Trauma Coordinators have been placed at each trauma center to assist the hospital in revising their organizational plans for receiving the critically injured patient. These coordinators are now working to develop the emergency communications and transportation system across the state. They are coordinating ground and air medical transportation and are responsible for the dispatching of aircraft for initial evacuation of casualties and for inter-hospital transfer of patients. They know the location, types, and capability of all aircraft and transportation devices within their region of responsibility. They also are coordinating the trauma center activities with the local, area, and mutual aid Civil defense directors for reaction in the event of disaster. The Trauma Coordinator is a strong new health initiative in Illinois.

Obituaries

***Alt, Howard Lang,** Evanston, died February 12, at the age of 71. He was past secretary, vice president and president of the Chicago Society for Internal Medicine and consulting hematologist, Children's Memorial and Veterans Administration Research hospitals; for many years affiliated with the Passavant Memorial Hospital.

***Baker, Morton G.,** Chicago, died February 15, at the age of 58. He was on the staff of Walther Memorial Hospital.

****Boim, Leon,** Oak Park, died at the age of 77. He was a former physician and surgeon at Hines Veteran's Administration Hospital, and a physician for more than 50 years.

***Boland, Joseph J.,** Oak Park, died May 27, at the age of 73. He was a graduate of the Loyola Medical School and was on the staff of St. Mary of Nazarath Hospital for 45 years.

****Brust, Edmund George,** McHenry, died January 23, at the age of 78. He was a physician in Melrose Park for more than 50 years.

****Elghammer, H. William,** Chicago, died January 25, at the age of 77. On the faculty of his alma mater, the Loyola University Stritch School of Medicine, he was affiliated with LaRabida Sanitarium and Mercy Hospital. He was a physician for more than 50 years.

****Gehl, William H.,** Chicago, died June 25, at the age of 79. He was a former chief surgeon at Augustana, Columbus, Grant and Illinois Masonic hospitals. He was a physician for more than 50 years.

***Greenspan, Irving,** Skokie, died February 12, at the age of 48. He was on the faculty of the Chicago Medical School and on the staff of Louis A. Weiss Memorial and Skokie Valley Community Hospitals.

***Hohner, Joseph J.,** Park Ridge, died June 23, at the age of 68. He was on the staff of Columbus Hospital and maintained offices in Chicago.

****Jaffe, Joseph,** Chicago, died January 20, at the age of 83. He was a physician for more than 50 years.

****Jeffries, Willard,** Iowa, died April 26. He was a physician for more than 50 years.

****Klein, Samuel,** Aurora, died June 26, at the age of 89. He was a graduate of the Loyola University Medical School, and a physician for more than 50 years.

***Levis, William,** Springfield, died April 1972.

***Meyer, Charles,** Western Springs, died May 26, at the age of 61. He was long associated with Cook County Hospital. In practice for 34 years, he was the first physician in the Chicago area to pilot his own plane for professional use.

***Mozan, Alphonse Adam,** Chicago, died January 3, at the age of 62.

***Neilson, William George,** Kewanee, died January 7, at the age of 64. He was past president of the Henry-Stark County Medical Society and past president of the staffs of St. Francis Hospital and Kewanee Public Hospital.

***Rife, Berry Volney,** Anna, died February 9, at the age of 74. He served on the staff of the Union County Hospital.

****Roos, Julius,** Lake View, died at the age of 74. He was on the staff of Columbus and Cuneo Hospitals. He had been an examining physician for the selective service for 25 years.

***Schneewind, John H.,** Chicago, died at the age of 56. He was a professor of surgery at the University of Illinois College of Medicine and the author of several books on medicine and surgery. In 1962 he was one of two physicians responsible for pioneering surgery that restored the severed hand to a 41-year-old Chicagoan. In that surgery, major blood vessels were sleeved and sewed and circulation restored.

***Stewart, E. H.,** Chicago, died at the age of 52. He received his degree from Northwestern University.

***Vermeren, John C.,** Antioch, died at the age of 70. He retired in 1961.

***Walton, Joseph E.,** died April 28.

**Indicates member of ISMS.*
***Indicates member of ISMS and Fifty-year Club.*

BLUE SHIELD REPORT FOR Illinois Physicians

Blood Supply Information Center to Open; State Network Will Follow

Illinois Blue Cross and Blue Shield have created a blood information center, designed to fill a critical need in the entire Metropolitan Chicago Area. The center will aid hospitals in locating whole blood supplies as quickly as possible whenever they are needed.

Prior to establishing the center, there was no single system available for locating and classifying whole blood supplies, since most institutions utilizing blood do so independently. With a blood information center in operation, whole blood supplies can be located with a single telephone call—an extremely important factor in emergencies and disasters, as well as under normal circumstances.

At the start, the center will service only hospitals in the Chicago area, and is intended as a base for a blood information network that will cover the entire state. Plans are that it will begin operating by mid-September from a facility in the lobby of the Illinois Blue Cross and Blue Shield building at 222 North Dearborn Street, Chicago.

The center will provide service 24 hours a day, seven days a week.

Trained personnel in the center will call a list of hospitals and blood banks each day to keep an up-to-date record of blood supplies. A "hot line" will be available for incoming calls only, so that information can be obtained without delay in emergencies for the use of hospitals and supplemental blood banks exclusively.

Initially, the information center will have only records on quantities of blood shortages and surpluses, by type and location. Later, however, records will also be kept by age grouping to assist in substantially reducing the outdating of whole blood.

When a hospital needs a supply of a particular blood type, an authorized person from that hospital will call the information center with the request. The duty-operator will inform the person where the nearest supplies of that particular type can be located, and the hospital will arrange a pickup.

To facilitate transmission of information on blood supplies, the Metropolitan Chicago Area has been divided into seven regions: Mid-City, Near North, Far North, Near West, Far West, Near South, and Far South. Hospitals and blood banks are grouped by these regions.

Blue Cross and Blue Shield developed the project in cooperation with the Metropolitan Chicago Blood Council in support of the all-volunteer blood donor system which the Council is sponsoring. The Blue Cross-Blue Shield Plans are financing the entire project as part of their continuing public service program.

Fall Workshops for Medical Assistants Scheduled

With summertime activities ending, a new series of Daytime and Dinner Workshops for medical assistants sponsored and conducted by the Professional Relations Department of the Blue Shield Plan, Illinois Medical Service is underway for the fall season.

This is the 15th year the meetings have been held. They are intended to help medical assistants keep abreast of the changes in Blue Shield structures, procedures and methods, including assisting in the processing of Medicare claims.

Four Dinner Workshops were held in late August and early September in Kane, Will, DuPage, and Lake Counties with meetings well attended. The following have been scheduled for the remainder of September and the months of October and November:

Sept. 27	Ramada Inn—Dolton (Dinner Workshop)	Cook County South Suburban
Oct. 4	Hyatt House (Dinner Workshop)	Cook County Northeast Chicago
Oct. 11	Arlington Park Towers (Dinner Workshop)	Cook County Northwest Chicago
Oct. 18	Oak Park Arms (Dinner Workshop)	Cook County West Suburban
Oct. 25	Marriott Motor Hotel (Day Workshop)	Cook County
Nov. 1	Continental Plaza (Day Workshop)	Cook County
Nov. 8	Foree Restaurant (Dinner Workshop)	Cook County Southwest Chicago

For additional information, please write or telephone Mrs. Loretta O'Donnell, Professional Relations Representative, Professional Relations Department, Blue Shield Plan of Illinois Medical Service, 222 North Dearborn Street, Chicago, Illinois 60601. Telephone (312) 661-2964.

ASK BLUE SHIELD
. . . ABOUT MEDICARE

Sufficient Data Needed to Expedite Claims on Long-Stay Hospital Cases

All too often, the absence of specific medical data from physicians filing claims for attending long-stay hospital patients, cause unnecessary delays between receipt of request for payment and approval for payment under Supplemental Medical Insurance of the Health Insurance Program, Part B Medicare. Since payment cannot be made for services not clearly medically necessary, it is necessary for us to have concise and meaningful data on hospital visits.

Under provisions of the Medicare law regarding such coverage, the Medical Department of Blue Cross and Blue Shield reviews a large number of claims involving prolonged hospital stays. In the majority of cases when payment is delayed or disallowed, either the care provided the patient was determined to be *custodial* in nature, or daily visits by the attending physician *did not appear to be medically necessary.* In many instances it was found that the latter portion of the hospital stay was not approved for payment because hospital services which had been provided appeared to be *principally custodial* in nature.

So that physicians' SSA 1490 Request for Payment claim forms may be more expeditiousiy processed, certain guidelines are suggested:

—Depending on the diagnosis, or diagnoses, daily visits will be approved for the *initial 20-25 days* of the stay, and longer if indicated. Also, depending on the diagnosis, visits during the remainder of the stay will be approved at frequencies of once, twice or three times a week;

—Physicians should provide *specific information* regarding the dates and nature of any *complications* which contribute to the long stay. In such instances, professional reviewers will be better able to judge daily in-hospital visits over even longer periods of time;

—There will be instances in which some of the in-hospital visits will be disallowed, but in reality were medically necessary and reasonable. In such cases, if the physician will provide *meaningful additional data* which demonstrates the medical necessity for continued daily in-hospital visits over a longer period of time, the initial disapproval can be corrected and payments can be provided.

Part B Medicare Deductible And The Deductible Carry-Over

Now is a good time to refer to provisions of Part B Medicare benefits as they apply to the Deductible Carry-Over.

Persons eligible for Part B Medicare benefits *must* meet a deductible of $50 in each calendar year before payment can be made for covered expenses. Even if a person is not eligible for the *entire* calendar year, the full $50 must be met. Non-covered expenses *do not* count toward the deductible.

Expenses which are incurred during the months of October, November and December which are applied toward the deductible for that year, may be applied toward the deductible for the following year.

Thus a charge of $30 incurred in October, 1972, which is applied toward the 1972 deductible, may also be applied toward the 1973 deductible leaving $20 of the 1973 deductible still to be met.

However, if a patient satisfies the deductible through expenses incurred prior to October 1 of a given year, charges incurred after October 1 are not applied toward the deductible, and the entire $50 deductible for the following year must be met.

The carry-over rule has been established to help the beneficiary who might otherwise have to meet the $50 deductible twice in a comparatively short period.

LET US HELP

For assistance in matters pertaining to Blue Shield in general and Medicare in Cook County in particular, contact one of our representatives in the Professional Relations Department, Blue Shield Plan of Illinois Medical Service, 222 North Dearborn Street, Chicago, Illinois 60601. Phone 661-2963.

(This report is a service to the physicians of Illinois)

IMJ illinois medical journal

volume 142, number 3 September, 1972

staff

editor Theodore R. Van Dellen, M.D.
managing editor Richard A. Ott
assistant editor Joyce Sevits
executive administrator Roger N. White

special reports

Legislative report 245
Abstracts of board actions 182

clinical articles

The post ragweed syndrome
Donald L. Unger, M.D. 189
Medical aspects of college football
Stephen E. Reid, M.D. 191
Trends in gonorrhea ecology
Domingo D. J. Leonida, M.D.; Ann A. Modrijan, R.N.; and Elizabeth Dogot, R.N. 199
Maternal death study, case report number 7
Robert R. Hartman, M.D. 213
Recrudescence of preventable communicable diseases
Abraham Gelperin, M.D. 218
"Hot-Line", crisis counseling service for pregnant women
Eugene F. Diamond, M.D.; and Rosemary Diamond, A.B. 220

special article

An FDA overview of nutritional guidelines and nutritional labeling
Robert M. Schaffner, Ph.D. 205

trauma center

A plan for organization of emergency services on Chicago's north side
David S. Forkosh, M.D. 209

surgical grand rounds

Osler-Rendu-Weber Syndrome and Meckel's diverticulum 195

features

the presidents page 171
editorial 198
the view box 204
practice management 208
ekg of the month 215
investment corner 216
pulse of the doctors wife 222
what goes on 224
american association of medical assistants—illinois society 230
new pharmaceutical specialties 234
doctors news 239
obituaries 254

(Cover by Mike Ahearn)

Microfilm copies of current as well as some back issues of the *Illinois Medical Journal* may be purchased from Xerox University Microfilms, 300 North Zeeb Road, Ann Arbor, Mich. 48106.

Published monthly by the Illinois State Medical Society, 360 N. Michigan Ave., Chicago, Ill., 60601.
Copyright, 1972, The Illinois State Medical Society.

Subscription $5.00 per year, in advance, postage prepaid, for the United States, Cuba, Puerto Rico, Philippine Islands and Mexico. $7.50 per year for all foreign countries included in the Universal Postal Union. Canada $5.50 U.S. Single current copies available at 75c.

Second class postage paid at Chicago, Ill. and at additional mailing offices. When moving please notify Journal office of new address including old mailing label with notification, if possible. POSTMASTER: Send notice on form No. 3579 to Illinois State Medical Society, 360 N. Michigan Ave., Chicago, Ill. 60601.

Pharmaceutical advertising must be approved by the ISMS Publications Committee. Other advertising accepted after review by Publications Committee or Board of Trustees. All copy or plates must reach the Journal office by the fifteenth of the month preceding publication. Rates furnished upon request.

REGISTERED AIA MEDIA DATA FORM

'Original articles will be considered for publication with the understanding that they are contributed only to the Illinois Medical Journal. The ISMS denies responsibility for opinions and statements expressed by authors or in excerpts, other than editorial or allied views or statements which reflect the authoritative action of the ISMS or of reports on official actions, policies or positions. Views expressed by authors do not necessarily represent those of the Society; any connection with official policies is coincidental.



If you are considering weight reduction, consider

Preludin®
phenmetrazine hydrochloride

Endurets®
prolonged-action tablets, 50 mg.

Often effective for short-term use as a dietary adjunct in weight-reduction programs.

Prolonged action Once-a-day dosage

Preludin® (II)
phenmetrazine hydrochloride NF

Indications: Preludin is indicated in exogenous obesity as a short-term (a few weeks) adjunct in a regimen of weight reduction based on caloric restriction.
Contraindications: Advanced arteriosclerosis, symptomatic cardiovascular disease, moderate to severe hypertension, hyperthyroidism, known hypersensitivity or idiosyncrasy to sympathomimetic amines, and agitated states. Patients with a history of drug abuse. Do not use with other CNS stimulants or MAO inhibitors. Use within 14 days following the administration of monoamine oxidase inhibitors may result in hypertensive crises.
Warnings: Tolerance usually develops within a few weeks. When this occurs, the recommended dosage should not be exceeded in an attempt to increase anorectic effect.
Drug Dependence: Tolerance and extreme psychological dependence have occurred. Patients have been known to increase the dosage of drugs of this type to many times the recommended dosage. Abrupt cessation following prolonged high dosage results in extreme fatigue, mental depression, and reversible changes in the sleep EEG. Manifestations of this chronic intoxication include severe dermatoses, marked insomnia, irritability, hyperactivity and personality changes. The most severe manifestation is psychosis, often clinically indistinguishable from schizophrenia.
Caution patients on the possibility of impaired ability to operate machinery or drive a motor vehicle or engage in other potentially hazardous activity.
Usage in Pregnancy: There have been clinical reports of congenital malformation associated with the use of this compound but a causal relationship has not been proved. Until more information is available, Preludin should not be used by women who are or may become pregnant, particularly in the first trimester, unless the physician feels potential benefits outweigh possible risks.
Usage in Children: Not recommended for use in children under 12 years of age.
Precautions: Use with caution in patients with mild hypertension. Insulin requirements in diabetes mellitus may be altered in association with anorectic agents and concomitant dietary regimen. Psychological disturbances may occur in some patients on a restrictive diet with or without concomitant use of an anorectic agent.
Adverse Reactions: Overstimulation, restlessness, insomnia, anxiety, headache, agitation, flushing, tremor, sweating, dizziness, dryness of the mouth or unpleasant taste, urticaria, gastrointestinal disturbances, nausea, diarrhea, palpitation, tachycardia, elevation of blood pressure, urinary frequency, dysuria, and changes in libido. Psychotic states at recommended dosage have been reported with related drugs.
(B)98-146-560-H(1/72)

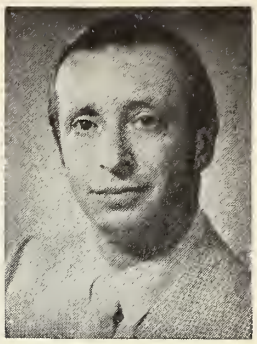
Under license from
Boehringer Ingelheim G.m.b.H.

For complete details, including dosage, please see the full prescribing information.

GEIGY Pharmaceuticals
Division of CIBA-GEIGY Corporation
Ardsley, New York 10502

PR 6648

the presidents page



It's Time to Yell *FOUL!*

The government has limited private practice physicians to fee increases of 2.5 percent a year . . . while institutions which employ salaried physicians may increase charges up to 6 percent annually.

No other profession . . . lawyers, CPA's architects . . . are subject to, or limited by, these restrictions. Only private practice physicians are stinted by the 2.5 percent figure.

Small businesses are now witnessing a removal of price control restrictions. And many small businesses were not affected in the first place.

Gentlemen, I believe it's time we yell, "FOUL!"

These exceedingly stringent regulations actually discriminate against physicians in private practice. And as Phase 2 of the economic controls continues . . . these flagrant injustices grow more and more conspicuous.

WE must compete with hospitals and other institutions in hiring and PAYING nurses, technicians, secretaries and clerks . . . yet regulations permit the institutional providers to raise their prices and pass on increased labor costs.

WE employ small local legal and accounting firms for necessary services and our businesses are housed in the same buildings with NO rent ceilings . . . but they are not subject to the 2.5 percent restrictions.

WE buy our pharmaceuticals, medical and office supplies and equipment from small supply houses or local merchants . . . yet most of these small businesses are not subject to wage and price regulations.

Do physician's fees actually have that much impact on the economy? Is this curbing the rate of inflation?

Actually, physician's fees are a very small factor . . . 1.4 percent of the Gross National Product goes for our fees. If the economy needs restricting . . . it seems the logical answer would be to control those segments which command the bulk of the consumer's dollar . . . food, housing, clothing. Yet manufacturers, retailers and sellers of services are generally permitted a full pass-through of their increased costs.

Our costs are going up just like everyone else's and rising liability insurance rates prove it . . . increases that range from 56 to 144 percent.

Many physicians have held the line on fees despite rising costs. Now these physicians are being penalized with substandard levels of fees. Yet they too must compete.

Let's look at the statistics! Statistics comparing the first nine months of the Economic Stabilization Program to the previous nine months. Keep in mind the goal of the Health Services Industry Committee and the Price Commission was to reduce the rate of inflation by ONE-HALF.

All Services Index . . . up 2.16 percent during the first nine months of the Economic Stabilization Program . . . compared to a 3.03 percent rise during the previous nine months; Semi-private Hospital Room Index . . . up 3.84 percent . . . compared to 6.62 percent; Consumer Price Index . . . up 2.05 percent; physician's fees . . . up only 1.37 percent . . . compared to 4.38 percent in the previous nine months.

OURS is the only increase that is less than one-third of the previous nine month's increase . . . well within the "one-half" goal that none of the others met.

And gentlemen, we can proudly say that this was mainly a self-imposed restraint.

We too are concerned about inflation. . . . We too share the President's interest . . . and are willing to help!

We only ask that the limitations be shared EQUALLY by ALL components of the economy.

We ask for fair play . . . not favoritism.

Frank J. Jirka Jr. M.D.

Physicians don't need a regular check up.

When a physician comes to us to borrow money, he gets the kind of treatment he deserves. We don't think it's necessary to ask a lot of involved or embarrassing questions.

Even if you want to borrow important money, like $15,000 for new equipment. Or enough to buy that sail boat you've always wanted.

We promise you preferred rates with no red tape or hassle. Tell us what kind of deal you want, and we'll try to work it out for you.

For some uncomplicated financial help call Jim Shea at (312) 661-5841. Jim's one of the people who make the difference at American National.



And he's ready to give you our special treatment.

The Idea Bank
American National Bank and Trust Company of Chicago

LaSalle at Washington 60690
Phone (312) 661-5000 Member FDIC

...in the presence of spasm or hypermotility, gas distention and discomfort, **KINESED®** provides more complete relief:

- ☐ belladonna alkaloids—for the hyperactive bowel
- ☐ simethicone—for accompanying distention and pain due to gas
- ☐ phenobarbital—for associated anxiety and tension

Contraindications: Hypersensitivity to barbiturates or belladonna alkaloids, glaucoma, advanced renal or hepatic disease.

Precautions: Administer with caution to patients with incipient glaucoma, bladder neck obstruction or urinary bladder atony. Prolonged use of barbiturates may be habit-forming.

Side effects: Blurred vision, dry mouth, dysuria, and other atropine-like side effects may occur at high doses, but are only rarely noted at recommended dosages.

Dosage: *Adults:* One or two tablets three or four times daily. Dosage can be adjusted depending on diagnosis and severity of symptoms.

Children 2 to 12 years: One-half or one tablet three or four times daily. Tablets may be chewed or swallowed with liquids.

STUART PHARMACEUTICALS | Division of ICI America Inc. | Wilmington, Del. 19899 | Pasadena, Calif. 91109

(from the Greek **kinetikos**,
to move,
and the Latin **sedatus**,
to calm)

KINESED®

antispasmodic/sedative/antiflatulent

Each *chewable tablet* contains: 16 mg. phenobarbital (warning: may be habit-forming); 0.1 mg. hyoscyamine sulfate; 0.02 mg. atropine sulfate; 0.007 mg. scopolamine hydrobromide; 40 mg. simethicone.

Chuckwalla (*Sauromalus obesus*):
This southwestern desert lizard seeks
shelter in crevices of rocks.
When attempts are made to probe him
from his niche, he gulps air
until his torso is distended up to
sixty per cent over its normal size...
thus wedging himself tightly
in place and preventing capture.

Abstracts of Board Actions Board of Trustees Meeting

These abstracts are published so that members of the Illinois State Medical Society may keep advised of the actions of the Board of Trustees. It covers only major actions and is not intended as a detailed report. Full minutes of the meetings are available upon any member's request to the headquarters office of the ISMS.

July 15-16, 1972 **Chicago, Illinois**

Hold Harmless Insurance Policies

The Board of Trustees approved a Statement of Understanding to be used by ISMS members prior to treatment of patients covered by insurance policies that promise to hold the insured patient "harmless" from physician charges exceeding the insurance company's set reimbursement. The action results from Aetna Life and Casualty Co. offering to pay the cost of defending patients who may be sued by doctors attempting to collect fees beyond those allowed by the insurance company. The Board was advised that in two other states Blue Shield is now selling policies which promise to hold the insured patient "harmless."

The statement of understanding emphasizes the doctor-patient relationship and provides that decisions relating to medical care and fees will not be affected by any contract either may have with a third party. Other organizations will be advised of the ISMS action.

Committee To Study IDPA Programs

The Board reactivated its Health Care Financing Committee to study problems of fee reimbursement under the Illinois Department of Public Aid. This committee will review a resolution which Wayne County proposes to introduce to the 1973 House of Delegates, directing ISMS to recommend and promote a dramatic medical welfare program for the state of Illinois, including IDPA purchase of comprehensive health care policies for public aid recipients and providing cash grants for welfare patients to pay deductible portions directly. Also to be referred to this committee is a letter from the Illinois Academy of Family Physicians calling attention to the IDPA practice of reimbursing physicians for less than their usual and customary fees. Because of the legislative implications, these matters also will be considered by the Board's Committee on Priorities.

Leadership Conference

Subject of the 1972 Leadership Conference will be "Dispute Settlements in Health Service Areas," the use of arbitration as an answer to the medical malpractice problem. In addition, part of the program will be devoted to informing physicians how to avoid problems with insurance companies which insist on dictating physician fees and offer to help defend patients against paying the physician's usual and customary fee. The Illinois Hospital Association and American Arbitration Association will be asked to participate.

Malpractice Claims Information

ISMS will begin collecting its own statistics on malpractice claims in an effort to get at the root of the problem and provide a solution. Because such information is only available from private insurance companies or individual

county courts of the state, the society will ask its members through various publications to voluntarily provide details of malpractice suits filed against them.

At the request of Johnson and Higgins, insurance brokers studying the Illinois malpractice problem for ISMS, representatives of appropriate councils and committees will meet with company officers to discuss the degree of physician involvement to be anticipated if J&H should administer a malpractice insurance program for ISMS in the future.

During the 77th General Assembly an unsuccessful effort was made to exempt from liability those members serving on HASP committees. The Board agreed that such legislation should be reintroduced in January, 1973.

Licensure

The ISMS Executive Committee has been authorized to prepare a position statement on licensing to present to a legislative commission meeting August 23 where testimony will be heard on this subject. Representatives of the Council on Education and Manpower will be involved in developing this statement setting forth the ISMS position on relicensure of physicians and certification of physicians' assistants and other allied occupations.

Blood Bank Legislation

The ISMS Laboratory Services Committee will be augmented with expert help to review blood legislation from the last session of the Illinois General Assembly. Beginning October 1, blood used for transfusions must be labeled as either purchased or donated. This new law is expected to cause physicians to avoid the use of purchased blood, especially after hepatitis exemption legislation expires next year. This law temporarily protects physicians and hospitals from legal action by victims of hepatitis acquired through blood transfusion.

Federal Methadone Regulations And Control Of Dangerous Drugs

The Board agreed with the Council on Mental Health and Addiction that ISMS should object to the following Department of Justice regulations: that methadone be withdrawn from pharmacies, that all drug detoxification be done in hospitals, and that patients under 18 be excluded from methadone treatment.

The council also called for greater enforcement of licensing standards by the Department of Registration and Education, calling the Board's attention to an Illinois physician whose license was renewed after his county medical society had expelled him and reported his documented history of over-prescribing of dangerous drugs.

Hospital Licensing Board Regulations

The Board referred back to the Council on Mental Health and Addiction the matter of Regulation 19-3.3 of the Hospital Licensing Board, which requires the consultation by a psychiatrist in order to admit a psychiatric patient to a hospital. The Board, which previously questioned the restrictions, did not agree with the council's support of the regulation.

Constitution And Bylaw Changes

The Board has directed that all county medical societies be informed of the changes in the ISMS Constitution and Bylaws voted by the 1972 House of Dele-

(Continued on page 225)

ISMS officers and trustees

ILLINOIS STATE MEDICAL SOCIETY

360 N. Michigan Ave., Chicago, 60601

OFFICERS

Frank J. Jirka, Jr., *President*
1507 Keystone, River Forest, 60305

Willard C. Scrivner, *President-Elect*
Suite 2, 6600 W. Main, Belleville, 62223

Joseph Skom, *First Vice-President*
707 Fairbanks Court, Chicago, 60611

Glen Tomlinson, *Second Vice-President*
Fantus Clinic, Cook County Hospital,
1825 W. Harrison, Chicago, 60612

Jacob E. Reisch, *Secretary-Treasurer*
1129 S. 2nd Street, Springfield, 62704

Paul W. Sunderland, *Speaker*
214 N. Sangamon Street, Gibson City, 60936

Andrew J. Brislen, *Vice-Speaker*
6060 W. Drexel Boulevard, Chicago, 60637

TRUSTEES

JOSEPH L. BORDENAVE, 1st District (1974)
1665 South St., Geneva, 60134

ALLAN L. GOSLIN, 2nd District (1974)
712 N. Bloomington, Streator, 61364

DAVID S. FOX, 3rd District (1973)
20829 Greenwood Center Ct., Olympia Fields, 60461

ROBERT T. FOX, 3rd District (1973)
2136 Robin Crest, Glenview, 60025

EUGENE T. HOBAN, 3rd District (1975)
6429 North Ave., Oak Park 60302

FREDRIC D. LAKE, 3rd District (1975)
1041 Michigan Ave., Evanston 60202

WILLIAM M. LEES, 3rd District (1974)
6518 N. Nokomis, Lincolnwood, 60646

GEORGE SHROPSHEAR, 3rd District (1974)
1525 E. 53rd, Chicago, 60615

PHILIP G. THOMSEN, 3rd District (1974)
13826 Lincoln, Dolton, 60419

FREDERICK E. WEISS, 3rd District (1973)
15643 Lincoln, Harvey, 60426

WARREN YOUNG, 3rd District (1975)
3450 Haweswood Dr., Crete, 60417

FRED Z. WHITE, 4th District (1973)
723 N. Second St., Chillicothe, 61523

A. EDWARD LIVINGSTON, 5th District (1973)
326 Fairway Dr., Bloomington, 61701

MATHER PFEIFFENBERGER, 6th District (1975)
State and Wall St., Alton, 62002

ARTHUR F. GOODYEAR, 7th District (1973)
142 E. Prairie St., Decatur, 62523

EUGENE P. JOHNSON, 8th District (1973)
P.O. Box 68, Casey, 62420

WARREN D. TUTTLE, 9th District (1975)
203 N. Vine St., Harrisburg, 62946

HERBERT DEXHEIMER, 10th District (1975)
301 S. Illinois, Belleville, 62220

JOSEPH R. O'DONNELL, 11th District (1974)
444 Park, Glen Ellyn, 60137

CHARLES J. JANNINGS, III, *Trustee-At-Large*
101 E. Center, Fairfield, 62837

WILLIAM M. LEES, *Chairman of the Board*
6518 N. Nokomis, Lincolnwood, 60646

PUBLICATIONS COMMITTEE

Jacob E. Reisch, M.D., Springfield, *Chairman*

Eugene T. Hoban, M.D., Oak Park
Frederick E. Weiss, M.D., Harvey
Glen Tomlinson, M.D., Chicago
Warren W. Young, M.D., Crete

Contributing Editors

Theodore R. Van Dellen, M.D., *Editor*

Contributor in Surgery
John M. Beal, M.D., Chicago

Contributor in Medical Progress
Harvey Kravitz, M.D., Skokie

Contributor in Trauma Medicine
David Boyd, M.D.C.M., Chicago

Contributor in Radiology
Leon Love., M.D., Maywood

Contributor in Cardiology
John R. Tobin, M.D., Maywood

IMJ
Illinois Medical Journal
Vol. 142, No. 3, September 1972

The Post-Ragweed Syndrome

By Donald L. Unger, M.D./Des Plaines

For many ragweed sensitive patients, the worst symptoms occur not in August and September, but in October when little ragweed is in the air. At this time hospitals fill with wheezers (Table I) and allergists see more sick patients than at any other time of the year. The term "post-ragweed syndrome" has been suggested for this condition*; its causes are the subject of this paper.

A ragweed sensitive patient will have little difficulty on first contact with an average amount of ragweed, but continued exposure causes increasing symptoms. Connell[1] has termed this "the priming effect." If 400 ragweed grains are aerosolized into the nose of a ragweed sufferer during the winter, little will happen; the same amount given daily for three days causes marked obstruction and by day four, one-fifth of the original dose produces severe blockage. This priming effect is not limited to the antigen used.[2] Alternaria is the most important mold in the Middle West and many patients are sensitive to both ragweed and alternaria; those primed with ragweed can have a tremendous response to relatively small amounts of alternaria. While there is less alternaria in October than in August and September[3] (Table II), the patients sensitive to both over-react to the alternaria present in October.

The term was first suggested by my late technician, Miss Tybee Sue Meyers.

After the ragweed season, many patients develop respiratory infections. Obstruction of any part of the body is often associated with secondary infection which may persist after the obstruction is removed. Just as a urethral stricture may be followed by a urinary tract infection, so also may hay fever precede a sinus infection and asthma lead to infectious bronchitis. Whether the infection acts as an antigen or a non-specific irritant is obscure,[4] but it does aggravate the underlying allergy. Antibiotics often are helpful.

While most people assume that dust is a non-seasonal antigen, it has a sharp seasonal variation. When heating units are turned on in late September, dust emerges that may have been in the air vents for six months. Interestingly, patients with central air conditioning join in dating their troubles to turning on the heat, even though their ducts have been in use all summer; they, too, describe a definite dusty odor with the first heat.

TABLE I

	Jan.	*Feb.*	*March*	*April*	*May*	*June*	*July*	*Aug.*	*Sept.*	*Oct.*	*Nov.*	*Dec.*
1969	6	11	13	15	7	5	21	11	7	14	22	9
1970	12	11	4	13	14	8	4	6	8	16	4	6
1971	7	3	8	7	10	10	4	3	6	16	10	9
Total	25	25	25	35	31	23	29	20	21	46	36	24

Number of patients admitted to Lutheran General Hospital (Park Ridge) for Asthma, by Months.

Weather may relate by being hot one day and cold the next. This can irritate the asthma[3] or precipitate the associated infection. Air pollution is twice as great in October as in August and 54% higher than in September[5] (Table III), probably due to increased home heating. In October, 1971, there was only 1/6 the air pollution present in October, 1964[3] (as measured by the sulfur dioxide concentrations in Chicago), but the patients seemed no better.

The importance of dead leaves is difficult to assess, perhaps because while alternaria grows on them, counts for this mold are lower in October than in August or September. Until recent years, October meant burning leaves and smoke, but patients have failed to improve since the burning of leaves has stopped.

TABLE II

Place	*Year*	*August*	*September*	*October*
North Chicago, Illinois	1970	353	513	107
Hinsdale, Illinois	1970	630	989	418
"	1969	428	629	396
"	1968	423	611	730
Ann Arbor, Michigan	1970	842	781	370
"	1969	713	578	378
Peoria, Illinois	1969	162	330	190
Madison, Wisconsin	1971	324	1,056	178
Milwaukee, Wisconsin	1971	772	1,425	1,263
"	1969	591	653	181
"	1968	834	721	475

Alternaria Counts in Recent Years for August, September and October[3]

TABLE III

	1964	*1965*	*1966*	*1967*	*1968*	*1969*	*1970*	*1971*	*Average*
August	.020	.027	.021	.018	.012	.010	.014	.009	.016
September	.040	.030	.028	.022	.009	.012	.019	.008	.021
October	.060	.049	.053	.027	.013	.031	.016	.010	.032

Sulfur Dioxide Concentration in Parts Per Million—Chicago City-Wide Average[5]

Thus, there are many factors causing the post-ragweed syndrome. The priming effect of ragweed makes the patients over-react to alternaria and dust; this is probably the most important cause as the condition occurs mainly in ragweed sensitive patients. Other factors include changeable weather, infections, turning on the heat, increased air pollution and perhaps the presence of dead leaves. Of course, the common household antigens such as dogs, cats and feathers are more damaging when the windows are closed in October than when they are open in summer. The condition ends when the first killing frost destroys the alternaria; this is usually about November 1st in the Chicago area. The old wives' tale about the ragweed season ending with the first frost is therefore true for many patients, even though there may have been no ragweed in the air for a month before that time. ◄

Donold L. Unger, M.D., is in the privote practice of ollergy ond is chief of the Deportment of Allergy, Loyolo University Stritch School of Medicine. He is o grodu-ote of Northwestern University Medicol School ond took residencies in both internol medicine ond ollergy. He is o post president of the Chicogo Society of Allergy.



References

1. Connell, J. T.: "Quantitative intranasal pollen challenge. II. Effect of daily pollen challenge, environmental pollen exposure, and placebo challenge on the nasal membrane," *J. Allergy* 41:123, 1968.
2. Connell, J. T.: "Quantitative intranasal pollen challenge. III. The priming effect in allergic rhinitis," *J. Allergy* 43:33, 1969.
3. Statistical Report of the Pollen and Mold Committee of the American Academy of Allergy: 1968, 1969, 1970, and 1971.
4. Unger, D. L.: "What provokes asthma attacks?" *Postgraduate Medicine* 44, 5 (Nov.) 1968.
5. City of Chicago: Department of Environmental Control; 1971.

Medical Aspects of College Football

By Stephen E. Reid, M.S., M.D./Evanston

Ever since the first football game in the United States, played between Harvard and Rutgers in 1869, this game has attracted a certain type of participant. The game produces violent contact between players and is certain to produce bodily injuries.

What attracts a boy to a game that exposes him to such violence and causes him to accept such a rigid discipline? What drives this boy back to the grueling scrimmage which has left him too exhausted to engage in the many campus social activities and still feeling the aches of multiple body bruises? There may be an explanation if this boy is the star of the team and is willing to make this sacrifice because of the attendant glory, but what inner drive causes a boy to persist in the sport when it is perfectly obvious to him that he will never be recognized for his playing? How can this game continue to attract a former star who has been beaten out of his position by an underclassman?

An athlete, as a successful businessman, likes competition and is driven by some motivating force. Motivation or desire is a variable quality in individuals and difficult to describe. Psychiatrists describe it as some deep-seated or deep-rooted psychological or emotional need which the athlete is trying to fulfill. These basic needs may be:

1. *Need for authority.* A boy may feel the need for discipline and uses the coach as the "father figure."
2. *Need for acceptance.* A boy from a broken home may feel rejected and if this need is not fulfilled in home or in school, he is likely to join some anti-social gang.
3. *Need for status.* Just as there are status seekers in other phases of life, an athlete too may seek status with his physical ability. The boy from a family of great athletes may feel that his status in the family requires him to engage in the game.
4. *Need for success.* A boy who feels inadequate in other activities may use football as his opportunity to succeed.
5. *Need to strengthen the self-image.* The boy who has overcome some physical defect that has labeled him as a weakling will want to compensate for this failing and develop into a great athlete. This group includes the good little men on the team.

What motivates the football player is not important but the realization that such motivation exists is essential for the physician to adequately care for an injury. The husky, 250 pound football player will cry when he receives a painful injury but the agony is because he has to leave the game and not because of the pain. The doctor who is unaware of this degree of motivation or who is not favorably disposed towards this attitude should not treat the injured athlete. The physician who is overly cautious in treating an injured athlete or who may even recommend that the boy quit this foolish game, will drive this boy into the hands of people ill-prepared to care for the injury. The doctor must make a

thorough evaluation of the injury and unless there is a real contra-indication to continue to play, he must see that this boy is restored to as nearly perfect physical fitness as possible. An unstable knee joint, for example, that results from an injury may be perfectly satisfactory for a person in a sedentary occupation but it will not afford the security required for football.

The injured athlete differs from another patient in that there is a greater urgency to restore this boy to optimum physical fitness to meet the football schedule. Decision about treatment must be prompt and the course selected must be the one that will more nearly guarantee fitness in the shortest possible time. The doctor who is undecided about the degree of an injury to a knee, for example, should not procrastinate for several weeks to see what happens when the leg is "rested in a cast." This type of care causes muscle atrophy and will not guarantee accurate apposition of torn ligaments so necessary for a stable knee joint. When an arthrotomy is finally done a much longer reconditioning period is necessary and results in the athlete missing a whole football season or losing his position on the squad. An athlete who finds the doctor sympathetic to his problem will be a very cooperative patient and his motivation to get well will hasten his recovery. The doctor is dealing with a strong, healthy body and convalescence from injuries need not be prolonged. In private practice he is often impressed with the rapid progress children make following surgery, compared to the long convalescence of the fearful patient who is suspicious of pain in early ambulation. The patient with no great urgency to get well is also bound to have a slow recovery. Injured athletes, on the other hand, are anxious to get back to the team and will endure any discomfort to accomplish this goal.

A most important phase of athletic injuries is prevention. This phase encompasses supervision, coaching, conditioning and protective equipment. Until rather recently, the safety of the athlete has been largely the responsibility of athletic officials. The character of the game changes constantly and over the past twenty-five years many radical changes have taken place. The power play of the single wing system has been replaced by the speed and deception of the T-formation. This has resulted in a wide open game with players running greater distances and developing more momentum.

A "man in motion" allows a player to develop his speed before the play starts. This emphasis on speed is illustrated by the fact that the football player today is bigger and faster than was needed for the "three yards and a cloud of dust" type of play of the single wing system. When one considers that kinetic energy is a product of the mass and the square of the velocity, it easily can be seen that any increase in speed greatly magnifies the energy created when the modern football players move at their maximum velocity. As a result of these changes in tempo, football has changed from a contact sport to a collision sport. Before each season the Football Rules Committee legislates the conditions of play as a result of their appraisal of the incidence of injuries incurred during the previous season. As this game has changed, circumstances have developed where injuries are more likely to occur. This group is aware of the fact that when a player is not alert to the possibility of contact, he is likely to be injured. For this reason a foul is called if a player makes contact with an opponent who has stepped out of bounds or after the whistle has blown or when the punter is off balance and standing on one foot. The fair catch rule allows the receiver to concentrate on catching the punt without the worry of being tackled. Clipping is another example of a foul play because of the possibility of injury. Because of the increased incidence of injuries on kick-offs, the receiving team has been spread over a greater area on the field to prevent the amassing of large numbers of players around the receiver. Any unnecessary roughness or unsportsmanlike conduct is subject to penalty. When the face mask became standard equipment it soon became apparent that grasping the mask by an opponent could create considerable leverage on the cervical spine. This was declared illegal because of the real chances of injury to the neck. After years of experimenting with the substitution rule, it was finally decided to permit liberal substitution to allow a coach to withdraw a player from the game if there was any question of injury or fatigue without jeopardizing his chances of returning to the game. Game officials are selected not only because of their knowledge of the rules of the game but also on their interest in the protection of the players from injury.

Medical supervision of the athlete has progressed from the coach to the athletic trainer and at the college level to the physician. As the responsibility of the coach increased, a trainer came into the picture and this position was filled by anyone available. Today, the athletic trainer is a college graduate with training in physical therapy. About 75% hold teaching appointments

in the university, usually on the subject of care and prevention of athletic injuries. The trainer's relation to the team physician is similar to the relationship that exists between the resident and the staff physician in the hospital. The National Athletic Trainers Association, founded in 1950, holds annual meetings where key speakers discuss the practical approach to injuries.

The medical profession has not played a very active role in the prevention of injuries in football. The larger colleges and professional teams have team physicians but high schools and smaller colleges rely on the neighborhood doctor, or any physician who happens to be available, for their medical care. These doctors, however, are not a part of the team and offer little more than occasional on-the-spot care. These physicians often know very little about the game and less about the motivation of the individual players. The National Collegiate Athletic Association suggested to the AMA Board of Trustees that a medical advisory committee was needed to safeguard the health of the athlete. In 1956 the AMA Committee on the Medical Aspects of Sports became official. National conferences on the medical aspects of sports are held in conjunction with the annual clinical convention of the AMA. Many medical societies hold athletic injury conferences throughout the country where coaches and trainers are invited and given instructions in the recognition and first aid treatment of injuries. Physicians realize that sports medicine requires a specialized type of care that is quite different from any other field of medicine.

The health and safety of the football player is largely the responsibility of the coach. Careful instructions in the fundamentals of the game and coaching good clean football greatly reduce hazards of the sport. Coaches must discourage tactics which are likely to cause injury. When a player, for example, uses his head as an offensive weapon he is likely to strike with his neck flexed or in a neutral position and is unable to see his target. This posture can cause injury to an opponent but is more likely to result in a neck injury. This is referred to as spearing and must be discouraged. Some years ago this tactic was used at Northwestern and resulted in several "pinched nerves" in the necks of football players. When it was determined to be due to spearing it was discontinued and the number of neck injuries was drastically reduced. Coaching clinics are held throughout the country to instruct younger coaches and students of the game in football fundamentals. The Committee on Injuries and Fatalities of the American Football Coaches Association has kept accurate yearly statistics on football fatalities since 1931. The modern football coach is a polished gentleman with a college degree who specializes in the instruction of young men in a sport that thrills millions of spectators and satisfies the desires of the players.

A spectator is not aware of the fierce body contact that is encountered in football unless he is on the sidelines at a game. The players must undergo rigid conditioning in order to endure such impacts. This type of development is largely the responsibility of the coach and includes mental as well as physical conditioning. This process begins with the boy's initial experience with the game and continues throughout his football career. The game automatically eliminates the boy who is not fit for this body contact but those that remain must strengthen certain muscle groups which are vital to the protection of ligaments spanning joints. The bull neck and the well conditioned quadriceps group of muscles supporting the knee are examples of such development. These athletes can extend the knee ten times repetitively against a resistance of over 100 pounds. Conditioning is stressed throughout the year because injuries are more prevalent in the early part of the season when conditioning is not completely attained in the alloted time before the first game. Following an injury a good deal of this conditioning is lost and if it has not been regained, recurring injuries are likely to occur.

Certain areas of the body cannot be protected by conditioning and these require protective equipment. As the charaacter of the game has changed, so has the quality of protective equipment. The modern smooth plastic helmet has replaced the old leather variety. With the addition of a face mask, the football player has little fear of injury. Modern shoulder pads of durable light-weight plastic distribute the force of impact



Stephen E. Reid, M.D., M.S., is ossociote professor of surgery, Northwestern University Medicol School ond speciolizes in generol surgery. He is o grodvate of Northwestern University, where he ployed collegiote footboll, ond served internship ond residency ot Evonston Hospitol. A Diplomate of the Americon Boord of Surgery, Dr. Reid hos done reseorch in rodiotelemetry regording brain waves of footboll ployers upon impoct during octuol gome conditions.

over a wide area and protect shoulders from direct blows. Hip pads protect the bony prominences of the pelvis and kidneys and yet are light enough so the player's agility and speed are not hampered. Low cut shoes with interchangeable cleats of varying lengths are worn to improve upon speed and maneuverability. The ankle is supported by heavy taping which restricts lateral motion in the ankle and although it protects the ankle, most certainly creates more strain on the knee ligaments when impacts are received on the lateral aspect of the lower leg.

Even with these preventive measures of supervision, coaching, conditioning and protective equipment, injuries do occur and these require first-rate diagnoses and treatment.

Football injuries may be classified in many ways and will depend upon the experience of the players and upon the degree of success a football team enjoys. The young, inexperienced player who receives an injury will react to it to such a degree that he must be withdrawn from the game, but after a year or two of "experience" this same boy will hardly be aware of the fact that he has received a similar injury. After a hard fought game that the team wins, players are unaware of many relatively minor injuries and cannot be bothered with any treatment of them. Yet these same players, after losing a game, will be quite concerned about simple abrasions and slight muscle contusions. Any injury that is so slight that no playing time is lost should not even be considered in the injury category. These include superficial lacerations, abrasions, hematomas, some muscle contusions and minor sprains and strains. These injuries are part of the game and their inclusion merely confuses statistics.

Football injuries may be classified as serious, major and minor. Serious injuries are those that are potentially fatal or result in some degree of permanent disability. Serious injuries involve the head, neck and spine and those due to trauma of internal organs—chest and abdomen. Major injuries are those that result in loss of more than three weeks of the football season. These include severe injuries to joints, muscle and fractures. Minor injuries result in loss of less than three weeks of football practice.

Summary

The football player is a highly motivated athlete engaged in a game that is likely to produce some degree of bodily injury. These can be kept at a minimum by proper supervision, coaching, conditioning and modern protective equipment. Team physicians realize that an athletic injury requires a different approach than is usually employed in treating a wound of the general public. This type of injury occurs in a healthy, well conditioned young man who has great urgency to recover and will endure any discomfort to hasten the healing process. He expects to be restored to as nearly perfect physical fitness as possible and, therefore, must not be returned to the game until he has regained the conditioning that was lost as a result of the injury. ◄

Minor Injuries	*Fall, 1968*	*Fall, 1969*
Sprains	13	11
Strains	12	6
Contusions	2	1
Fractures	2	1
Dislocations	1	0
Head Injuries	1	6
Totals	31	25
Major Injuries		
Knee Injuries	4	4
Neck Injuries	0	1
Internal Injuries	1 (kidney)	0
Fractures	0	1 (Fibula)
Dislocated Shoulder	0	1
Head Injury	1	0
Totals	6	7
Severe Injuries	0	0
	37	32

Injuries that occurred during the 1968 and 1969 seasons of the Northwestern University varsity football team are representative of the type and number usually encountered.

Leadership Conference

Plans are underway for the annual Leadership Conference of the Illinois State Medical Society. Problems of malpractice insurance, the increasing numbers of claims, and alternative methods with possible resolutions to this problem will be the chief topic. See further detailed information on page 250.



surgical grand rounds

Edited by John M. Beal, M.D.

Osler-Rendu-Weber Syndrome and Meckel's Diverticulum

Surgical Grand Rounds are held weekly on Tuesday, at 5:00 P.M., in the Offield Auditorium, Passavant Memorial Hospital. Patient presentations from Passavant, Chicago Wesley Memorial and the Veterans Administration Research Hospitals form the basis of the discussions. This case report was part of the Surgical Grand Rounds of May 4, 1971.

Case Report:

Dr. Robert Davis: A fifty-seven-year-old white man was awakened in the middle of the night with an urge to defecate. He passed a stool which he described as approximately two quarts, containing bright red blood. At this time he fainted in the bathroom, was found by his daughter, and brought to Chicago Wesley Memorial Hospital. A history of hematemesis, abdominal pain, recent change in bowel habits, weight loss, and recent melana was absent. However, he had had a similar episode in September, 1970, when he was admitted to the hospital. At that time, X-rays of the gastrointestinal tract including small bowel and an air contrast study of the colon were unremarkable. He had a prompt return of his hematocrit to normal levels, and was followed as an outpatient. In January, 1971, the X-rays were repeated and proctoscopic examination was performed but were within normal limits. The remainder of his past history and review of systems was essentially negative.

When physical examination was performed, his vital signs were within normal limits. He was a well-developed white man who was notably pale. His abdomen was soft and not distended. Bowel sounds were present and normal. Admission hematocrit was 35%, hemoglobin was 11.3 gm and the white blood cell count was normal. A coagulation profile was within normal limits. X-ray consultation was obtained.

Dr. Earl Nudelman: At the time of his examination, the patient was felt to be actively bleeding, and it is important that patients be actively bleeding at the time of angiography. We were unable to inject a large enough volume of contrast material because of the fact that the patient had a very short celiac trunk. The inferior mesenteric artery, superior mesenteric, celiac axis origins were felt to be within normal limits. In the area of the cecum and terminal ileum there is a collection of contrast material noted on several series of films, each following a separate injection of contrast material. (Fig. 1). A small collection of slightly irregular vessels is noted in the area of presumed contrast pooling. Also noted are prominant and relatively early draining veins. The venous structures are extremely well visualized, especially in view of the small amount of contrast material injected. The lesion is felt to be compatible with an angiodysplastic lesion of the cecum or possibly the distal ileum. This site is the common location for such lesions.

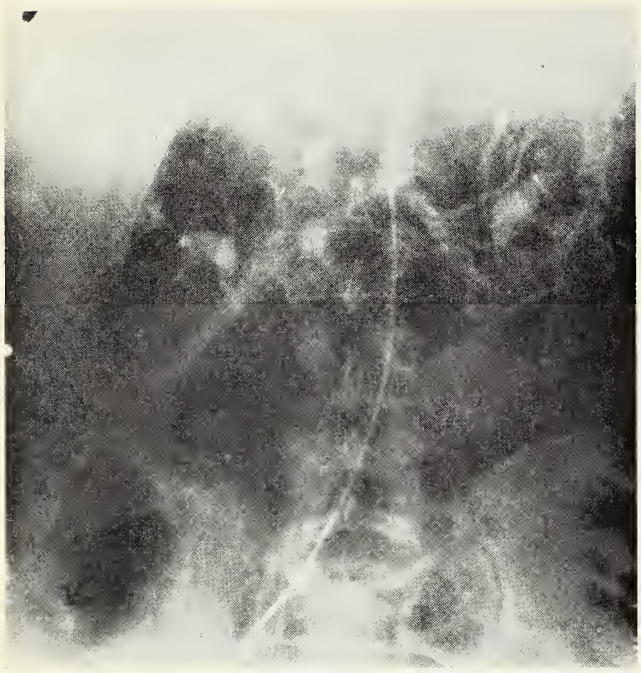


Figure 1. Controst ogent injected into superior mesenteric ortery during selective orteriography wos noted in the oreo of the cecum ond terminol ileum.

In the past, blind right hemi-colectomies were performed in patients with recurrent G.I. bleeding with fair results. Probably a significant number of these patients had angiomatous malformation of the distal ileum and cecum.

Dr. Richard Bass: What rate of blood can be detected by angiography?

Dr. Earl Nudelman: It varies. In animals they say up to 2-5 cc per minute is necessary in order to see pooling of contrast in the bowel lumen. Sometimes if we can just show the abnormal vascular artery and an early draining vein, then contrast pooling is not necessary to make the diagnosis of a small A-V malformation.

Dr. Robert Davis: The patient's hematocrit continued to fall and two units of whole blood were required. With a presumptive diagnosis of a carcinoma of the cecum, exploratory laparotomy was performed through a right paramedian incision. The colon was normal. When the small bowel was examined, a Meckel's diverticulum was found approximately two feet proximal to the ileocecal valve. In addition, from a point just distal to the ligament of Treitz and extending to the proximal portion of ileum, the patient was noted to have multiple telangiectasias. Therefore, we were confronted with the problem in a patient with a Meckel's diverticulum as well as multiple telangiectasia. The prospect of resecting approximately 10 feet of the patient's small bowel in the hopes to alleviate his bleeding from the telangiectasias was not a promising one. Because Meckel's diverticulum occasionally presents with hemorrhage, it was considered advisable to resect it. Meckel's diverticulum has been referred to as a disease of twos because it affects 2% of the population, is usually 2 feet from the ileocecal valve, is often two inches in length, occurs twice as often in males as in females, and usually contains two types of ectopic tissues, either gastric or pancreatic tissue. The two most frequent complications are hemorrhage or inflammation. Obstruction also occurs, usually in the adult. Meckel's diverticula are usually symptomatic in childhood, one-third in the first year of life, and 80% under 15 years of age. The Meckel's diverticulum was removed and sent to the pathology laboratory.

Dr. Hector Battifora: Most of the lining of the diverticulum was of a type very similar to the one normally found in the normal ileum. The predominant cell lining the surface of the mucosa is a mucous-secreting type. In some areas of the diverticulum there were clusters of glands, deep in the submucosa, and these are identical to those that are found in the duodenum, so called Brunner glands. Also, there were smaller glands containing numerous round cell-like with acidophillic granular cytoplasm. These are oxyphilic or parietal cells such as you find in the acid-secreting portions of the stomach. So this is an area of heterotopic gastric mucosa. Next to this area, we found a small active area of peptic ulceration (Fig. 2). There are numerous vessels in and around the area of ulceration, and in the bed of the ulcer, and it is conceivable that some of these were the cause of the bleeding. Dilated, angiectatic capillaries are also seen elsewhere in the submucosa.



Figure 2. Smoll oreo of ulcerotion in heterotopic gostric mucoso wos found in the Meckel's diverticulum.

Dr. Hines: We frequently see patients with gastrointestinal bleeding from an unknown source. Most of the time the bleeding has stopped when we explore the abdomen. Some of these patients have hemorrhages that occur for a few minutes or even an hour and then stop. The patient will continue to have black stools for one to several days. The surgeon is most fortunate who happens to operate on an intermittant bleeder while the site is actively bleeding. In these cases, he can go to the top of the column of blood and locate the source of the hemorrhage.

In this case we carried out the abdominal exploration with no knowledge of what to look for. We found two potential sources of bleeding. It was a matter of judgment whether to resect the first eight feet of small bowel loaded with the telangiectasia, or to remove the Meckel's diverticulum. The eight feet of small intestine contains a great deal of absorptive surface for digestion and removal of the Meckel's is relatively harmless. We decided that the most likely source in mathematical probabilities was the Meckel's, so we resected it. He hasn't bled for the three weeks he has been followed since surgery. It will require a year or two to know if he will bleed again as telangiectasia can bleed in later life. The Meckel's did have an active peptic ulcer with blood vessels in the base so we feel this was the site of bleeding at this time.

Dr. Nadim Khoury: We do see an occasional case. I think in the last three years, three or four cases were presented. Osler-Rendu-Weber Syndrome is a genetic disease transmitted dominantly and probably affects both sexes equally. This case is unusual in that 1) his first episode of bleeding was at the age of 57 so far as we can tell, 2) he doesn't have the typical lesions in any apparent site which is very unusual and 3) he doesn't have a family history of the disease. These are the three criteria necessary for an absolute diagnosis. The lesion, as you know, is a telangiectasia and really, what it is, is an arteriole portion of the bloodvessel devoid of the muscularis and the supporting elastic tissue, and as such is mainly made of endothelium. This results in sacular dilatation, and presents usually in the mucous membranes of the nose, the mouth, the lips, and the face and the fingernails, or the fingers. It is present very often in the gastrointestinal tract, but occasionally, these lesions are present in the lungs and in the genitourinary tract. When a patient bleeds and he doesn't have the skin lesions, or lesions that you can see, it is an extremely difficult diagnosis to make. Your routine X-rays are not going to be of much help, angiography would help once in a while, but you probably need, if he is having hemoptosis, a bronchoscopy which often will show the lesions. If he is bleeding from his genitourinary tract, cystoscopy might help. Also, a gastroscopy in this case might have shown some of the lesions. But obviously, you don't know what you are dealing with. These patients usually get along in their early teens without any problem. They start bleeding at about 20-30 years of age, and as they grow older the frequency of the bleeding and the severity of it progressively gets worse. Eventually they will develop an iron deficiency anemia and occasionally a patient that doesn't have the skin lesions or the mucous membrane lesions will present like this patient presented with bleeding and/or iron deficiency anemia.

The treatment usually is just to stop the bleeding; we try to use the least traumatic method. If he is bleeding from the nose, we try not to cauterize it, just apply pressure or something like that. Also, you have to be very careful not to transfuse these patients unless they really need it, because eventually they need more and more transfusions, and you will run the risk of hepatitis. There is one other complication that these patients have, they do have the lung lesions and this is often an arteriovenous fistula, which can be of good size. They might come to you because of polycythemia or because of cyanosis or clubbing early in the disease and this can be a very difficult problem to handle. They also might have this fistula infected and then they will have the picture of bacterial endocarditis, with thrombosis and mycotic emboli, especially to the brain.

Dr. B. Herold Griffith: We have gained some experience with these patients. We often see them before the general surgeons do because nasal bleeding is more common than G.I. bleeding. They may bleed massively from lesions in the nasal mucosa. From our standpoint, nasal bleeding is far more treatable than gastrointestinal bleeding. Unlike the general surgeon, we do not have a long bowel to worry about. One of our patients is in the Veterans Administration Research Hospital right now with G.I. bleeding. He is a man upon whom about ten years ago we did a complete relining of both sides of the nose with split thickness skin grafts. We did his first operation under general anesthesia, and because of massive bleeding during the

(Continued on page 203)



editorials

"Right" to Medical Care

Our nation now is struggling with the problem of improving our free way of life with or without more regimentation. It is a delicate, crucial situation because many prefer the use of legal force to correct our social problems. "Rights" are not freedoms, even though we consider the right to free speech and assembly as basic freedoms. Specifically, we refer to the "right" to medical care proposal. It does not take into consideration the rights of the person providing the treatment.

Being forced to give medical care touches on our most cherished freedom—freedom from conscription so that physicians will not be forced to labor against their will. The medical community always has had compassion for the sick and poor, but the use of legal force to provide treatment is not in keeping with the way society provides other necessities to the needy, including food, clothing, and shelter.

According to Meyerhoff,[1] "It provides it (food) by supplying the (starving) person with the means by which all free citizens make their necessary purchases. It does not conscript anybody to supply the services or goods, nor does it dictate to the poor by giving them specific goods and services it deems desirable. It rather maintains the maximum of freedom by giving them money with which they can freely make purchases as they regard the basics to be. . . ."

There is a growing tendency for governments to forsake the customary ways of freedom by adopting policies under the guise of "a better life for all." Soon the beneficent government talks itself into thinking that "In order to feed the hungry, in order to tend the sick, we must forsake our free ways." Our inalienable rights must not be jeopardized. We still can have a better life, adequate food, and good health within our democratic system.

T. R. Van Dellen, M.D.
Editor

1. Meyerhoff, Gordon R.: *The 'Right' to Treatment, Medical Tribune* (Doctors' Debate) (June 14) 1972, pg. 18.

Trends in Gonorrhea Ecology

By Domingo D. J. Leonida, M.D., M.P.H., M.S./Mapleton; and
Ann A. Modrijan, R.N., B.S.N. and Elizabeth Dogot, R.N., B.S.N./Kenosha, Wisconsin

The sex revolution in progress and the fulminant course of attendant problems have defied description and analysis. Every suggestion pointing to an improved quality of life has become a dominant issue while the quest for a pleasurable life style has run rampant with unabated fury, regardless of the physical hazards in this Age of Aquarius. Gonorrhea has become the hottest epidemic. It has become the commonest bacterial disease in adults. In a majority of women it has been asymptomatic. They do not know they have the infection, thus they become the reservoir of gonorrhea without treatment. Gonorrhea almost invariably has been symptomatic among men. Therefore, treatment is sought fairly early.

Coexistence of venereal disease and drug-taking has assumed a significant role in clinical medicine.[1] Drug dependency among those attending venereal disease clinics of hospitals has been studied.[2] Coincidence of clinical disease and drug-taking has not been unique to venereal disease patients.[3] That drug use might be a reaction to physiologic and environmental stresses has been considered by some writers.[4,5] Gonorrheal complications have been considered more seriously as differential diagnoses in examining young people.[6] As venereal disease rates increase, especially among school-age children, community and group dynamics exert dominant functions. Population density, susceptibility, the role of personal and environmental hygiene, and the impact of biological variation upon disease in a school population should not be overlooked.[7] Ecological spectra, including occupations, residences, and gonorrheal transmission potentiale among the clientele of a city health department's venereal disease clinic, have been studied to further define the gonorrhea-drug ecology from 1969 to 1971.

Procedures

A minimum of six interviews has been held with each person attending the Kenosha Venereal Disease Clinic from March, 1969, through January, 1971. These interviews have been conducted by one or two public health nurses and the clinic physician. Recording of repeated data (by design) has been a major feature of these interviews. Emphasis has been directed to the more frequently repeated data pertaining to onset of suspected illness, duration, alleviation of complaints through drugs, occupation, residence, contacts, possible disease of contacts, contacts on drugs, and treatment of contacts.

Effects of drugs have been categorized as hallucinatory, sleep-inducing, sleep-inhibiting, and no effect experienced. The data accuracy depended upon the extent that the clinic clientele has provided accurate data.

Types of drugs:

1. Sleep-inducing (hypnotic-sedative variety)
2. Sleep-inhibiting (sympathomimetic variety)
3. Hallucinogen

A graph of the ratio of gonorrhea patient contacts using drugs to the total number of contacts illustrates trends during 1969 through 1970 is shown in Figure 1.

Clients who have been diagnosed or suspected as having gonorrhea were asked information about residence, occupation, and contact frequency. Information about narcotic-type drugs was not requested. Gonorrhea or carrier potentiale has now been determined by

1. Number of contacts on drugs per case of gonorrhea with symptoms of or treated for gonorrhea;
2. Number of contacts on drugs per case of gonorrhea and untreated;

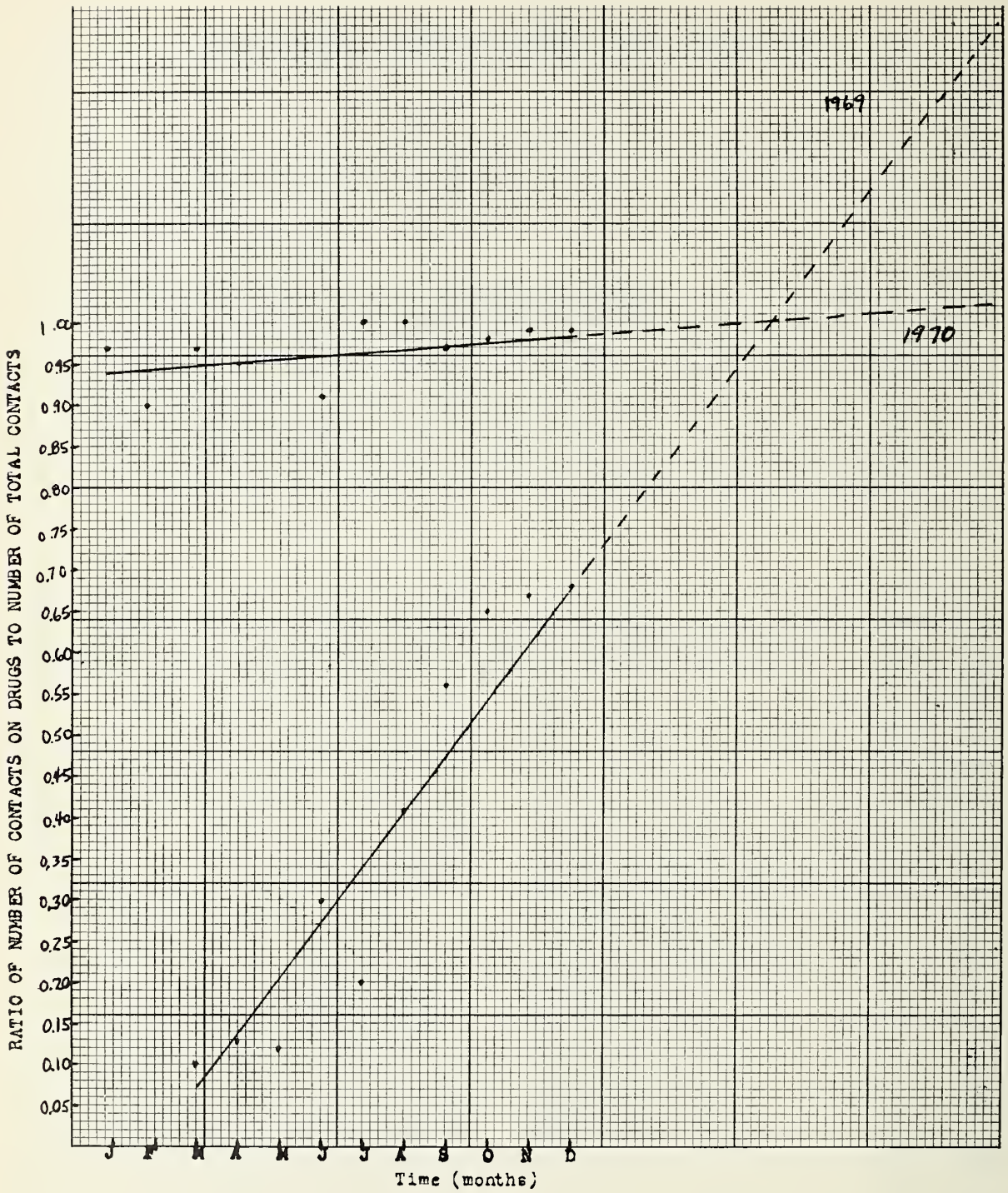


Figure 1. A Trend in Gonorrhea-Drug Ecology, 1969-1971

3. Number of contacts on drugs per case who were contacts of other known cases of gonorrhea or treated cases of gonorrhea (known to the client);
4. Frequency of contacts with contacts on drugs per month (to compute the annual number).

Determination of carrier potentiale has been attempted to select mainly secondary school students by assigning an index of 1^2 to facilitate clustering by age-groups. There are two four-year colleges and three senior high schools in the immediate area of Kenosha, Wisconsin. All age-groups over 19 years have indices of less than one, with two as an exponent. These determinations of carrier potentiale also have provided pertinent parameters that help to describe this clinic's gonorrhea-drug clients by making the calculations on data from the 25 most frequently treated clients, five per occupational subgroup.

During a 10-year period (1960-1969) gonorrhea in Wisconsin increased almost five-fold among people 15 years old and over.[8] Those 15-19 years of age had more than a seven-fold increase. Ecological factors have played significant roles in unravelling the epidemiology of clinical disease.[9]

Thus, this work focused upon certain characteristics of gonorrhea ecology with special reference to the student subgroup. By definition, the student subgroup includes young people from 15-19 years of age: whether in school (high school or college) or not attending school provided they had left or had dropped out from school less than two years ago. All other occupations are self-explanatory.

Results

Occupation

27% student
2% musician
3% laborer
63% unemployed
5% military personnel or dependent

Residence

4% migrant laborer (county)
72% city residents
24% from out-of-state or recently arrived for school but not migrant laborers

Carrier Potentiale		*Order of Carrier Potentiale*
Student	17x6x13x28	1. student (See Table 1)
Musician	11x9x 5x 4	2. unemployed
Laborer	4x4x 5x 6	3. military/dependent
Unemployed	14x4x16x20	4. musician
Military/ dependent	8x3x12x29	5. laborer

Index applied to age group from 15 to 19 to select mainly the secondary school students: 1^2

For ages over 19 years:

20-24=0.1^2 30-34=0.001^2 40-44=0.000001^2
25-29=0.01^2 35-39=0.0001^2

Discussion

The unemployed and the students formed the largest occupational subgroups attending the public clinic, 63% and 27% respectively. Military personnel on vacation or enroute to new stations and military dependents made the third

Table 1: ***Carrier Potentiale of 25 Most Frequently Treated Clinic Patients (5 Per Group)***

	per student	per musician	per laborer	per employed	per military/ dependent
Average number of contacts on drugs per case of gonorrhea (treated at clinic)	17	11	4	14	8
Average number of contacts on drugs per case of gonorrhea without symptoms and untreated	6	9	4	4	3
Average number of contacts on drugs who were contacts of *other* known cases of gonorrhea or/and treated cases (known to client)	28	4	6	20	29
Average coital frequency with contacts on drugs per month	13	5	5	16	12

Examples:
Ages 15-19: 17x6x13x28x1^2
Ages 20-24: 4x4x 5x 6x0.1^2
1^2 and 0.1^2 are the appropriate indices.

largest subgroup. The employed laborers and musicians formed the smaller subgroups.

Those who claimed to be residents of the city of Kenosha comprised 72% of the clinic clientele. Of the clinic participants, 24% expressed out of state residence and 4% were Kenosha county residents outside the city corporate limits.

There has been an increasing number of gonorrhea contacts having had drug experience. Average number of contacts of drug-venereal disease cases has been greater than or equal to four. Average number of contacts of veneral disease non-drug cases has been less than or equal to two. Interviews with each case treated for gonorrhea show an increasing drug influence among contacts of veneral disease index cases treated or referred to Kenosha Health Department for post-treatment follow-up. Also noted were the predominance of dependent personalities on drugs and increasing promiscuity.

Figure 1 projects a graphic view that the ratios of gonorrhea case contacts on drugs to total contacts have been sharply and remarkably increasing in 1969. By the beginning of 1970, the saturation point seemed to have been realized and the increments were not as dramatic as in the previous year. Ratios, however, remained high. If drug usage has been commonly a response to stress (of the extraordinary and the garden varieties) then the Venereal Disease Clinic should have included mental health services.

Some subjects are hesitantly communicative on first encounter, but show ability to warm-up to interviewer who does not discuss blame for venereal disease or does not seem to notice long hair, dirty hair and skin grime, types of clothing or ornaments worn by these contacts or clients. Information gathered did not mean excellent rapport with the subjects. Interviewers of the contacts have been able to elicit giggling (drug-effect notwithstanding) from the usually stolid, reticent, suspicious and anxious adolescents.

The group studied during the 1969-1971 period has not been presented with the implication that it *represented* a given community. At best, this group is merely a subpopulation and manifests some of the features traditionally known among public clinic clientele. This subpopulation may reflect changes already underway.

Table 1 attempts to classify data that exhibit good potentiale in venereal disease transmission. Five occupational classifications were made. The average number of sexual contacts with people on drugs pertained to a 12-month period: January 1-December 31, 1970. These are contacts of 25 most frequently treated clients at the public clinic during a 12-month period in 1970. This is one view of how the different social contracts and frequency of sexual contacts enhances the risk of venereal disease transmission among these 25 people.

When tabulated data are used with appropriate indices, the maximum contact potentiale for venereal disease transmission per age group can be determined quickly in terms of the decimal point location. Information thus collected can be retrieved per age group without the use of electronic machines or computers, yet be fairly rapid in retrieval when using the appropriate index. Obviously, the maximum values obtained at this clinic were applicable only in terms of the experiences in 1970. The experiences of a later date may provide new maximum values for this group.

Venereal disease transmission potentiale of the student subgroup (15-19 years of age) was highest among the 25 most commonly treated patients and among 518 clients treated with Bicillin and Doxycillin from March, 1969, through January, 1971. Bicillin was also provided to physicians in Kenosha who wished to help treat the medically indigent. Interviews and epidemiologic follow-up of this subgroup were more timeconsuming than any occupational subgroup. The epidemiologic studies in following each case were not only time-consuming but most productive in bringing in contacts for treatment either at the private physician's offices or at the Kenosha Public Clinic.

Indices were developed to reflect the potentiale for venereal disease transmission. The highest numercial value referred to the highest transmission experience and the lowest for the lowest transmission experience. The study subgroup experienced the highest transmission of gonorrhea. Following this lead were the unemployed, military/dependent, the musicians and labor (employed) subgroups.

The secondary school and the university with the largest student enrollment had more cases of gonorrhea treated or examined at this clinic than those with smaller enrollments.[7] The sutdent density per school might be a factor in the rate of which gonorrhea or venereal diseases generally has been transmitted or conveyed from an infected to an uninfected student. This possibility could be studied easily if all venereal disease cases from each school and college were

examined and treated in the public clinic. Limited resources of the public clinic would make this task too formidable.

With reference to the treatment of gonorrhea, a 1968 survey of Wisconsin private physicians conducted by the American Social Health Association, only 14.6% of gonorrhea cases treated by private physicians were reported.[8] Therefore, gaps have existed in the data of treated gonorrhea reported or cases that might be referred to a public clinic in Wisconsin.

Conclusion

Although epidemiologic methods have not been exhausted in characterizing the gonorrhea-drug ecology or in processing the salient trends, description of the data gathered point to the following:

1. That the trend of gonorrhea contacts on drugs is clearly emphasized; some contacts were on drugs (1969), but in 1970 virtually all contacts were on drugs (three types).
2. That the gonorrhea-carrier potentiale was highest among the student and the unemployed subgroups, followed by the military/dependent, musician and employed laborer subgroups. The use of indices pertaining to gonorrhea transmission potentiale of specific age-groups was described.
3. That among the occupations manifesting the growing trend or tendency for gonorrhea and drug-use to coexist among the contacts of gonorrhea patients, the unemployed and the students formed the largest subgroups.
4. That city residents predominantly reflected this trend, followed by out-of-state residents. ◄

References

1. Linken, A., "A Study of Drug-Taking Among Young Patients Attending a Clinic for Venereal Diseases," *Brit. J. Vener. Dis.* 44:338 (1968).
2. Rawlins, D. C., "Drug-Taking by Patients with Venereal Disease," *Brit. J. Vener. Dis.* 45:238 (1969)
3. Hughes, J. E., Steahly, L. P., and Bier, M. M., "Marihuana and the Diabetic Coma," *J.A.M.A.*, 214:113 (1970).
4. Meeds, L., "Drug Abuse as a Reaction to the Stresses of Growing Up," *School Health Rev.*, 1:3 (1970).
5. Presto, A. J. and Muecke, E. C., "A Dose of Spanish Fly," *J.A.M.A.*, 214:591 (1970).
6. Maxwell, G. E., "Why All the Fuss about Gonorrhea?" *Today's Hlth.*, 43:24 (1965).
7. Leonida, D., "Morbidity Patterns in a School Health Program," *Illinois Med. J.*, 137:262 (1970).
8. Nashold, R. D., "Gonorrhea Cases Treated in Wisconsin, Calendar Year 1969," Wisconsin State Division of Health, Bureau of Health Statistics special communication.
9. Leonida, D., "The Ecological Characteristics in Clinical Tetanus," *Ohio State Med. J.*, 64:323 (1968).

Acknowledgement

The authors gratefully acknowledged consultation from Dr. R. D. Nashold, Chief, Statistical Services Section, Wisconsin State Division of Health, Bureau of Health Statistics, Madison, Wisconsin. The authors sincerely appreciated the review and typing of manuscript revisions by Mrs. Louise Markert and Mrs. Eva Adams of the Kenosha Health Department, Kenosha, Wisconsin.

About the Authors



Domingo Leonida, M.D. (pictured) is plant physician for Caterpillar Tractor Co., Mapleton, and clinician for the Venereal Disease Clinic, Tazewell Co. Health Dept. He is also an assistant coordinator in preventive medicine for the Peoria School of Medicine, University of Illinois. Formerly Director, Department of Health, Kenosha, Dr. Leonida is a graduate of the University of Cincinnati College of Medicine with his M.P.H. from the University of Michigan. He is a Diplomate, American Board of Preventive Medicine. **Ann Modrijan** and **Elizabeth Dogot** (not shown) are with the Kenosha Health Department.

Osler-Rendu Weber Syndrome

(Continued from page 192)

operation, we had to give him about four pints of blood. Since then we have done all of our patients under local anesthesia with adrenalin, and have had no more significant bleeding.

New little telangiectases continue to crop up, later on, if a really radical removal of the mucosa of the nose is not done. This includes the mucosa of the whole septum, the floor, and the lateral wall. A lateral rhinotomy is needed and must be continued superiorly with the nasal process of the maxilla being cut to provide access to the entire side of the septum. ◄

ADDENDUM:

The patient was examined five months after this presentation and had not developed evidence of further gastrointestinal bleeding.

References

1. Michaeli, D., Ben-Bassat, I., Miller, H. I., and Deutsch, V.: "Hepatic telangiectases and portosystemic encephalopathy in Osler-Weber-Rendu disease," *Gastroenterology* 54:929, 1968.
2. Osler, W.: "A family form of recurring epistaxis associated with multiple telangiectases of the skin and mucous membranes," *Bull J. Hopk. Hosp.* 11:333, 1906.
3. Weber, F. P.: "Multiple hereditary developmental angiomata (telangiectases) of the skin and mucous membranes associated with recurring hemorrhages," *Lancet* 2:160, 1970.

the view box

LEON LOVE, M.D./CHAIRMAN/DEPARTMENT OF RADIOLOGY
LOYOLA UNIVERSITY STRITCH SCHOOL OF MEDICINE

This is a case of a 21-year-old white female who presented with stunted growth, mongoloid facies splenomegaly and hepatomegaly. A loud systolic murmur was heard over the precordium. C.B.C. revealed a microcytic anemia. (Figures 1, 2, 3 and 4) What's your diagnosis?

1. Paget's Disease
2. Gaucher's Disease
3. Thalassemia
4. Hodgkins Disease

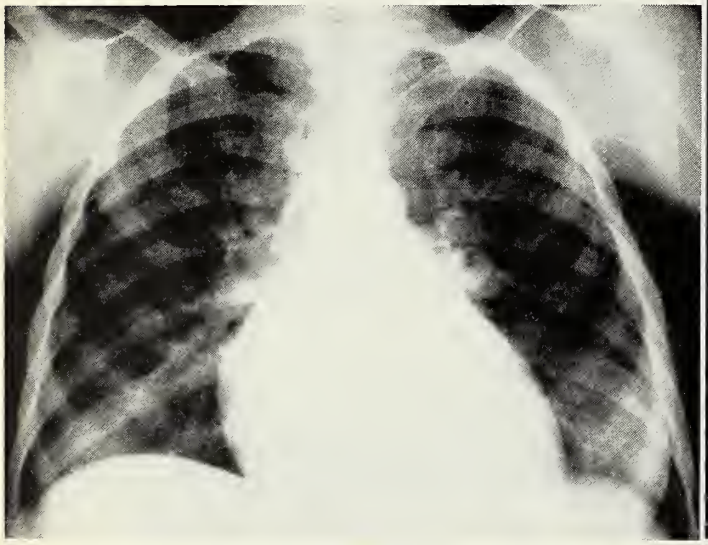


Figure 1.

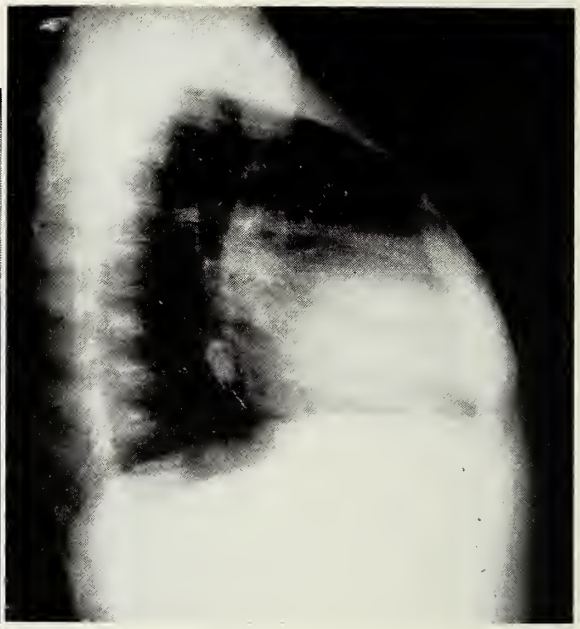


Figure 2.



Figure 3.



Figure 4.

(Answer on page 254)

By Robert M. Schaffner, Ph.D./Washington, D.C.

An FDA Overview of Nutritional Guidelines and Nutritional Labeling

Each year the FDA is charged with greater and greater responsibility regarding the food supply. Generally speaking, responsibilities fall in the area of food safety, quality and value. The three areas are listed in order of importance and certainly our number one priority in any work plan is the safety of the foods. Some time ago, Dr. Virgil Wodicka, Director of the Bureau of Foods, classified various hazards associated with foods in their order of decreasing importance. He classified them in this way:

1. Food Borne Diseases
2. Malnutrition
3. Environmental Contaminants
4. Naturally Occurring Toxins
5. Pesticide Residues
6. Deliberate Additives.

During the past months there has been considerable publicity in the food borne disease area. I am sure that the term botulism is now much more a household word than it was even a short time ago. Many of you are familiar with the proposed regulations that have been presented to us by the National Canners Association to lessen the chance of botulism getting into the foods and we are now actively pursuing this program. The details of this are subjects of other discussions.

I think it would interest you to know that malnutrition and the entire subject of nutritional adequacy of foods is from a priority standpoint second only to food borne diseases.

In December, 1969, the White House Conference on Food, Nutrition, and Health met in Washington, D.C. Numerous panels discussed nutrition from various viewpoints. Many of the panels called to the attention of FDA that labeling of foods provided little or no information on nutritive value except for some few foods for special dietary purposes. Nutrition education has for years struggled with the teaching of first the "basic seven" and then the "basic four" types of foods. But changes in food technology have produced so many formulated products that even if a housewife has a good idea of either the "basic four" or the "basic seven," she is frequently at a loss in knowing exactly how her needs are met by the consumption of many convenience foods that are formulated in our factories rather than those that start with raw materials prepared in the kitchen. Many nutritionists also questioned the widely held idea among food marketing people that nutrition would not sell products.

There were many suggestions from the Conference regarding the role Government agencies should play in the area of nutrition; if one were picked it was a recommendation that FDA consider the development of a system or systems for identifying nutritional qualities of foods. These suggestions started the setting up of plans and programs that would enable the consumer to have a good idea of the nutritional qualities of all types of foods, including both formulated ones and commodities which were preserved by canning, freezing, pickling, drying, etc.

Nutritional questions regarding formulated foods have been approached by the FDA by first asking the Food and Nutrition Board of the National Academy of Sciences to suggest guidelines for various types of foods. It was thought that first priority should be given to formulated frozen food dinners, and the Committee on Food Standards and Fortification Policy recommended the nutritional guideline for these dinners.

The Division of Nutrition in the Bureau of Foods, together with assistance from Offices of Compliance, Food Technology, and Science, reviewed the recommendations. A minimum number of calories, 340, was proposed, and it was stated that the product should contain at least

(1) a source of protein, (2) potatoes, rice or other cereal, (3) a vegetable other than the above, and minimum levels of various nutrients were suggested for protein, vitamin A, thiamin, riboflavin, niacin, iron and iodine. All interested persons were urged to comment on this proposal, and the Bureau of Foods is now reviewing over 180 comments that have been received.

Of course, a great deal of interest is being given to this first proposed guideline. Many segments of the food industry not directly engaged in the manufacture of this type of product have commented because everyone realized that the proposed guideline might have definite implications on other products.

I mentioned the fact that there have been many requests and suggestions that a uniform system of nutritional labeling be used on all foods. To get this program underway, a number of surveys and studies have been initiated by the FDA, various universities, the food industry, and consumer organizations. Although all of the surveys have not been completed, we believe that it is necessary to get a proposal in front of the public for comments by industry, the academic world and consumers.

Survey Results

Enough of the surveys have been completed, and I think you might be interested in some of the findings that were instrumental in helping us prepare the proposal. The first study was carried out by Dr. David Call of Cornell University and he surveyed professional nutritionists. Generally speaking, they recommended that the basis for labeling be the RDA (recommended daily allowances), and all of our proposals will be based on RDA's. A study conducted by "Chain Store Age" indicated that there was increased purchase of nutritionally labeled foods.

A second study had to do with three methods of labeling of nutrients. One type used the so-called positive adjective, where the terms applied to a particular food would indicate that it was an excellent, very good, good, fair, source of a particular nutrient. A second type used "units," each unit standing for 10% of the RDA. The third type used percentages. Three groups were studied: 2,000 homes on a national basis; slightly less than this number on a low income basis of $5,000 per year; a face to face survey of 600 people in the low income groups. Of the people questioned, 80% could properly select the product that had the highest nutritional value by using any of the methods of comparison; 50% favored the numerical approach as being best; 33% selected the adjective method; only 16% selected the unit form. Therefore, our proposal calls for the use of numerics on the basis of 10% intervals of the RDA above 20% and 5% intervals down to 5. It also calls for showing the statements on a per serving basis of: the number of calories to the nearest 5 calories; number of grams of protein, fat and carbohydrates expressed to the nearest gram. Questions will be raised about whether grams of protein should also be expressed on a basis of percentage increments based upon a 65 gram RDA value with percentages shown similar to those for other nutrients. In connection with the protein declaration, we are soliciting consumers and industry on how we would best declare the quality of the protein.

In the case of vitamins and minerals, the label declaration would contain information on vitamin A, thiamin, riboflavin, niacin, vitamin C, calcium and iron. There are, of course, some foods that do not have significant amounts of many of these nutrients, and we ask your opinion on whether zeroes should be shown for these when they are present in the amount of less than 5% or whether the term "none" or "insignificant" should be used. Many of course will classify such a statement as "negative labeling," but we want to get comments and thinking from all segments of the consuming public.

In various discussions regarding nutrition and labeling, the question frequently comes up "Does the consumer have the right to know the nutrient quantities of these products?" The Giant Food Store chain in Washington, in connection with their test labeling program, asked 3,000 consumers this question. More than 70% wanted this information and 97% said that the consumer had the right to see this information on products. Many feel that the consumer does have the right to have this information on the products purchased.

Questions have also been asked about who will pay for this information. I think we all realize that the consumer will be paying for it whether the information is obtained from the manufacturer or is developed by a government agency, because all of these things are paid for by the consumer.

We in FDA are interested in how these labeling claims are to be substantiated. The program, if adopted, will be a voluntary program, and the manufacturer can either make such labeling

claims in a nutrient information panel on his product, or he can elect to make no nutrient claims.

Questions have been raised regarding the enforcement of these claims. From time to time certain manufacturers have asked whether the information that is published in Handbook Eight of the Department of Agriculture is sufficient for his labeling. This could only apply to products of a commodity type. The Department of Agriculture, when they first issued this Bulletin, performed a very useful service to the consumers and to food manufacturers, but most of the data that are in these books are quite old, and there may have been many changes in the nutrient content of foods since then. For example, the breeding of different strains of fruits and vegetables may have brought about changes in certain nutrients, and changes in processing and differences in processing from manufacturer to manufacturer would also result in different nutrient levels. The FDA intends to enforce whatever regulation is put into effect, and if a manufacturer states a given level on his label he must meet this nutrient level. Falling back on Handbook Eight values will not necessarily suffice.

In order to allow for variations from lot to lot and package to package on nutrient value, we are suggesting that for a given lot of merchandise, at least 80% of the containers in that lot must contain as a minimum the nutrients claimed for on the label; and the remaining 20% of the lot must have nutrient levels of at least 80% those specified. We believe that modern technology and modern quality control methods are sufficient to make these practical values.

It would be almost impossible and extremely expensive if each manufacturer were to analyze each lot of merchandise to see that it met all of the nutrient claims that were stated on the label. However, we believe that a manufacturer should carefully analyze the nutrient values, particularly at each of his critical processing steps, to see at which steps the nutrient might vary considerably. Then if he sets up a monitoring program to get his process under closer control, he should achieve the nutrient values, and a minimum number of nutrient analyses should be necessary.

Our FDA people in the field periodically will be checking foods at the manufacturing and retail level to determine that the compliance with the label is being met. We will also use our current philosophy to determine whether or not the management systems in a plant are sound and are working satisfactorily. We are particularly concerned with quality control procedures. If it is determined that the quality control procedures necessary to assure the nutrient values claimed on the label are being closely followed, then we will be able to give the general public greater assurances that the nutrients are present in a given manufacturer's product.

Summing up, we believe that the White House Conference clearly indicated that the FDA should be more actively engaged in nutrient guidelines and nutritional labeling. The complexity of the formulated products makes it virtually impossible for the consumer to have any clear idea about the nutrients they are getting because they can no longer rely on the "basic four" or the "basic seven" as being the criteria for their shopping and eating habits.

Nutritional guidelines for frozen food dinners will be a starting point for setting guidelines for many other products. The proposal on nutrient labeling should provide consumer information on major foods.

Recent studies and surveys have indicated that the consumer wants to know this information, and we believe they have the right to know.

We also feel that if manufacturers supply this information, they can do much to overcome the lack of confidence that many consumers have in their current food supply.

Modern product development, food technology, and quality control procedures certainly should enable the food manufacturers to provide consistently high nutritional quality foods. We in the FDA are anxious to work to achieve goals for the overall benefit of the consumer. ◄



Robert M. Schaffner, Ph.D., is director of the Office of Food Technology, Bureau of Foods, F.D.A. He received his Ph.D. from the Horvord Business School and has had extensive experience in industry. This poper is one in o series presented at the 4th Symposium on Nutrition ond Food Technology sponsored by the Illinois Stote Medicol Society, the Chicogo Nutrition Association, and the Institute of Food Technologists.

This is one of a series of papers presented at the Fourth Symposium on Nutrition and Food Technology, March 29, 1972, Lake Shore Club, Chicago. The symposium was co-sponsored by the Illinois State Medical Society, the Chicago Nutrition Association, and the Institute of Food Technologists-Chicago Chapter.



practice management

Understanding Phase II Control

Part Two

Noel E. Young, Tax Specialists,
Professional Business Management, Inc.
67 East Madison Street, Chicago, Illinois 60603
(312) 782-2282

Since the guidelines and controls of Phase II are more complicated than they seem at first glance, explanations are quite necessary.

The Price Commission's ruling that medical fees may not rise more than an average of 2.5% a year may seem clear enough; but the ruling is hedged with many stipulations. The key words in the ruling are "on the average"—they mean that doctors may raise some fees by more than 2.5%, others less than 2.5%, and still others not at all. The over-all increase may not average more than 2.5%! However, doctor's fees cannot be increased at all unless they can prove higher costs and some objective evidence that costs have risen, i.e., present bills from suppliers. Furthermore, if fees are raised to cover higher costs, an increase must first be reduced by any increase achieved in productivity.

This is hard to do because increases in productivity are always difficult to measure and no branch of the government has yet issued guidelines on how the job should be done.

Next, fees cannot be raised so far that there will be an increase in the pretax margin of profit in relation to gross income. For example, expenses total 50% of the gross income meaning that the pretax profit margin in relation to the gross income is also 50%. Thus a doctor can increase his gross income in 1972 but cannot raise fees if such an increase would in and of itself push the pretax profit margin higher than 50%. Fortunately, in measuring a pretax profit margin, it may be related to the average of any two of the last three fiscal years ending before last August 15.

If physicians or medical groups do decide to raise fees, they do not notify anyone, but had best be prepared to justify the increases if the IRS sets up a challenge. Chances that it will do so are slim, for the IRS has only some 3000 agents to monitor the wage and price controls.

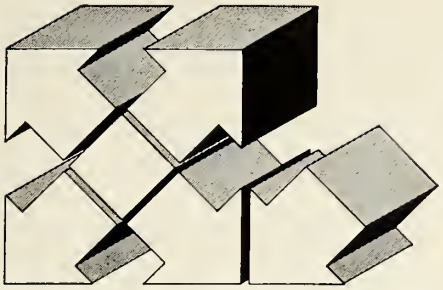
The guidelines on wages applies to both the doctor and his aides if the doctor is considered a salaried employee of a professional corporation. These guidelines are somewhat simpler to understand and use in comparison to the fees control. The basic rule is that wages may not go up more than 5.5% a year so long as Phase II lasts. Again, however, there are qualifications.

In the first place, the guideline applies to over-all wage increases. Thus, wage increases in a doctor's office as a whole may not exceed 5.5%, but individual increases may be less or more than that.

Another factor that would validate a wage increase in excess of the guideline is improvement of skill or promotion or a change in job classification.

In applying the guideline, the physician must remember to apply it against both wages and fringe benefits. Increases in wages and fringes taken together must not exceed 5.5%.

For a more personal application of these controls you should consult your professional business consultant, as the foregoing articles were intended to make you aware of a given situation and not to clarify a particular situation. ◄



trauma center

A Plan for the Organization of Emergency Services on Chicago's North Side

By David S. Forkosh, M.D./Chicago

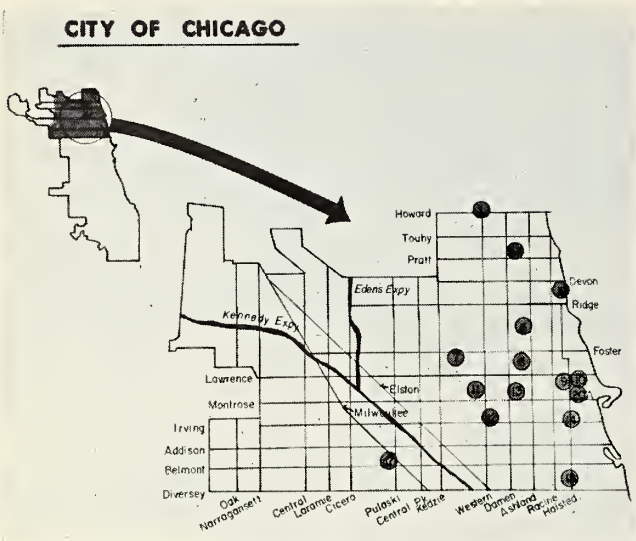
In September, 1970, Public Act 76-1858 became effective. This act allowed the establishment of areawide emergency service committees to plan categorization of joint emergency service programs. In early 1971, the Chicago North Side Commission on Health Planning, a health planning agency composed of representatives from the 14 member hospitals located on the North Side of Chicago and consumers and consumer representatives, appointed a planning committee to evaluate the possibility of organizing emergency services as provided for in the act.

The Committee was charged with: 1) preparing a comprehensive plan for emergency services which included categorization of the various hospitals' emergency capability; 2) coordinating with the Illinois State Trauma System;[1] 3) establishing a plan consistent with Public Act 76-1858; and 4) providing for close coordination with physicians in practice in the community.

The Committee was composed of physicians and administrators representing hospitals and medical staffs of various sizes throughout the target area. The Committee began its work with the feeling that while it was a planning committee, its work would soon be implemented into an improved system of emergency service in the target area (See Fig. 1, map). At monthly intervals and with constant feedback from medical staffs, community representatives and boards of trustees, the Committee finished the basic plan by August of 1971.

The plan as submitted to the Illinois Department of Public Health is PL 7-76-1858 (Illinois Senate Bill #568 of 1970).

The plan categorizes the various hospitals in the community into Types (A), (B), and (C), as provided by law. The (A) facilities are geographically spread across the community to provide easy access to ambulances and other vehicular traffic. The (B) facilities are also geographically dispersed. The (C) facilities tended



TYPE (A)
7. SWEDISH COVENANT HOSPITAL
10. LOUIS A. WEISS MEMORIAL HOSPITAL
13. RAVENSWOOD HOSPITAL MEDICAL CENTER
18. ILLINOIS MASONIC MEDICAL CENTER

TYPE (A) (PSYCHIATRIC)
9. FOX RIVER HOSPITAL

TYPE (B)
4. EDGEWATER HOSPITAL
5. NORTHEAST COMMUNITY HOSPITAL (on Sheridan Road)
12. MARTHA WASHINGTON HOSPITAL

TYPE (C)
1. BETHESDA HOSPITAL
5A. NORTHEAST COMMUNITY HOSPITAL
8. BETHANY METHODIST HOSPITAL
11. SYDNEY R. FORKOSH MEMORIAL HOSPITAL
14. AMERICAN HOSPITAL OF CHICAGO
17. BELMONT COMMUNITY HOSPITAL
20A. FRANK CUNEO MEMORIAL HOSPITAL

Figure 1. Map for Emergency Services on Chicago's North Side.

to be smaller community type institutions usually located close to an (A) or (B) facility. See Fig. 1.

Method of Self Categorization

The method of self categorization was achieved as follows: An initial questionnaire was sent to each member institution early in the course of planning. This questionnaire included the requirements for the various types of facilities, the availability of staff and equipment presently to be found in the individual institution and the institution's concept of its role in an areawide plan. This information was reviewed by the planning committee and in the vast majority of cases, the various institution's self categorization fitted into a cohesive plan for the entire community.

Agreement on Basic Principles

Once self categorization was completed, the problems of inter-hospital transfer and the continuity of medical care as well as the possibility of disruption of an ongoing doctor-patient relationship had to be reviewed. The plan provides for the delivery of seriously injured patients by public ambulance service to the receiving hospitals but does not prevent private ambulances from taking patients directly to the hospital of their private physician. If, however, a private patient is taken to a receiving hospital, the plan provides for the personal physician to have access to the patient and the records at the receiving hospital and also requires the receiving hospital to transfer the patient to the hospital of the patient's choice as soon as medically possible.

The plan also provides for referral back to the private practitioner of all patients seen but not hospitalized within the emergency system. In order to prevent the overloading of the receiving hospital by patients from the emergency system, the plan provides for the transfer to the hospital of his choice or the hospital closest to the patient's home as soon as it is medically feasible. Only if the patient has no personal physician will the patient be assigned a physician by the medical staff.

Once the planning committee was able to establish agreement on the basic principles above, the plan was committed to writing and submitted to the various hospitals' medical staffs, administrations and boards. Review and comments were sought from the required planning and governmental agency at the same time. By January, 1972, signatures of all member institutions were obtained.

Problems of Implementation

After the completion of the signing by the member institutions of the emergency room plan, the President of the Chicago North Side Commission on Health Planning appointed the chairman of the Areawide Committee, and each hospital designated a member of the Areawide Committee in accordance with the law. As this Committee proceeded to view the problems of implementing the plan, it became apparent that

there would be at least two areas which would require special attention. The first area of special attention was nursing coordination and education. The nurse members of the Areawide Committee felt that a subcommittee on nursing education and planning should be established. This committee was established and was composed of a representative from each member hospital and was further subdivided into subcommittees for the three types of emergency facilities. The subcommittees were able to sit down and work out parallel nursing procedures, inter-hospital transfer forms, as well as the all important development of inter-hospital communication on a nurse-to-nurse level.

The latter level of communication was felt to be extremely important, because it is the emergency room nurse who actually handles the majority of the administrative and procedural matters relating to emergency room patients. The state law requires doctor-to-doctor contact prior to an inter-hospital transfer, but it was felt by the nurses that nurse-to-nurse contact would also be necessary in order to facilitate emergency room care.

There were two main problems in education of emergency room nursing personnel. The first was familiarizing our present personnel with the plan and its implication on the individual hospital. The second was improving the education of nurses in the various categories so that they would be competent to handle whatever type of emergency room patient presented himself at their door. The state trauma network educational facilities will be utilized to upgrade the education of registered nurses, and also the areawide nursing committee will develop their own education programs for continual inservice education.

From an areawide point of view, the care of psychiatric emergencies required vast changes. It was soon discovered that emergency room personnel in the area's hospitals did not fully understand their community resources; therefore, a mental health subcommittee was organized. The subcommittee surveyed each hospital to ascertain its needs for emergency psychiatric consultation, beds on an emergency basis, and then delineated the community facilities available. In a series of meetings, it became apparent that the community had sufficient resources to provide emergency psychiatric care to those needing it without utilizing the facilities of the state hospital system. Information was dispersed through the mental health subcommittee to all emergency rooms and administrators explaining resources available. Twenty-four hour a day psychiatric consultation via telephones will be made available to E.R. physicians throughout the area. A central psychiatric bed availability registry is being developed. Existing crisis centers will become further publicized and hopefully, the need for emergency psychiatric commitment to state mental hospitals will be drastically reduced.

Coordination with State Trauma Network

A rational system of emergency room care can be viewed as a pyramid. The base of the pyramid is the areawide emergency plans which have patient flow into specialized care units. The top sections of the pyramid are the regional trauma centers with their highly specialized equipment and the specialized trauma centers, such as the pediatric trauma unit at Children's Memorial Hospital in Chicago and the burn units at Cook County and Loyola Hospitals.[2] The Areawide Emergency Service Committee established a relationship with the trauma unit at Evanston Hospital, and an agreement was worked out to extend the boundaries of the Evanston trauma unit to include the entire area of the Chicago North Side Commission on Health Planning. The pediatric trauma unit at Children's Memorial Hospital will become a keystone for pediatric trauma in our area. And finally, the Loyola University burn unit, while geographically not adjacent to our area, agreed to accept stabilized burn patients from our trauma system.

Ambulance Service

The efficient operation of our plan will depend upon the correct entry of patients into the program. Therefore, the initial delivery of injured patients will have to be shifted to those facilities with emergency room staffs able to provide the quality of care necessary for the individual patient. In order to accomplish this change, the traditional "nearest hospital rule"[3] will have to be eliminated. Communications were established through the Emergency Medical Services Commission for Metropolitan Chicago with the police and fire departments, and plans are presently being drawn to facilitate this change. A recent legal opinion has shown that changing the nearest hospital rule will require an amendment to the Chicago Municipal Code; steps are now being taken to draft such

an amendment.

Since the plan requires transfer of stabilized patients to their physicians or community hospital, a method providing appropriate ambulance service had to be developed. The Areawide Committee examined three possibilities: 1) such transportation to be provided by city services; 2) that one single ambulance company be selected to provide all inter-hospital transfer within the community; and 3) that each individual institution agree with an ambulance company of their choice to provide such ambulance service. After much discussion, of these alternatives, the first was eliminated because of budgetary problems. The second was also eliminated because it became apparent that no one single ambulance company could provide the necessary services for the population of our size in the event of a disaster; and finally, the third method was selected because it broadened the number of ambulances available and also fitted in closely with previously existing agreements between individual hospitals and ambulance companies for the provision of services.

Community Education

Probably the most important aspect of the implementation of an areawide emergency plan is community education. The Areawide Committee with the assistance of the Emergency Medical Services Commission for Metropolitan Chicago and Chicago Blue Cross-Blue Shield have developed various methods of community education.

When the plan is formally approved and announced, local governmental agencies will hold press conferences to provide mass media information about the plan. The Areawide Committee felt that brief splashes of news information will be insufficient to fully educate our community, and therefore, decided to develop other programs. The first is an information pamphlet explaining the plan and providing a map showing the location of various types of facilities. This pamphlet will be printed in languages consistent with our community and will be available in the admitting departments and emergency departments of all hospitals, and will also be distributed throughout the community through easily recognizable community organizations such as civic associations, churches, temples, schools, and boy scout and girl scout groups. A poster to be placed in a wide variety of locations such as store front windows, in parks, churches, temples and schools will also be developed to inform the population that a change has occurred in the pattern of emergency room service. Finally, a speakers bureau will be developed to provide speakers to various community groups wishing further information. It is hoped that a standardized slide presentation and standard speech will be developed so that the same information can be presented to all community groups. ◄

References

1. Flashner, B. A., et al., "The Critically Injured Patient: A plan for the organization of a statewide system of trauma facilities," *Illinois Medical Journal*, (March) 1971.
2. Boyd, D. R., et al., "Status Report: Illinois statewide trauma care system," *Illinois Medical Journal*, (January) 1972.
3. Gibson, G., "Emergency Medical Services in the Chicago Area," *Center for Health Administration Studies*, Chicago, Il. (December) 1970.



DAVID S. FORKOSH, M.D., is chairman of the Areawide Emergency Service Committee of the Chicago North Side Commission on Health Planning. He is a clinical assistant professor of medicine, Loyola University Stritch School of Medicine.

U. of I. Clinic Saves Arm, Kills Pain

The pain was so bad that the 21 year old accident victim pleaded with his doctors to cut off his arm. In their professional opinion, even though the shot gun shell had discharged—tearing a gapping wound in his shoulder and damaging nerves in his arm—amputation would be uncalled for.

Fortunately, the patient was taken to the University of Illinois Hospital. There a new Pain Clinic had been started under the direction of Dr. Alon P. Winnie, Head of the Department of Anesthesiology. Winnie relieved the patient's severe pain utilizing a "sympathetic nerve block." This broke the constant cycle of pain. After several treatments the patient was able to find lasting relief and his depressed mood changed to one of cheerfulness. He was up and walking with his arm intact.

Pain Clinics, although few and fairly new in concept, severe many different types of patients according to Dr. Winnie. Initial causes for the pain vary and include: pain of psychogenic origin, pain resulting from trauma, pain from serious or minor injury, and organic pain such as that caused by a lesion.

Edited By Robert R. Hartman, M.D./Jacksonville

Maternal death study

Case report No. 7

The seventh in a series of case reports

ONE OF THE FUNCTIONS of the ISMS Committee on Maternal Welfare is to analyze the causes of deaths in Illinois mothers and to determine, if possible, what alterations in management and treatment could have prevented any of these deaths. Each month a case will be presented and discussed in an attempt to promote more modern methods of obstetrical management. It is with extreme gratitude that the assistance of the Illinois Department of Public Health is acknowledged. Without their initial collection and preparation of the cases and protocols these studies would be very limited.

This 40-year-old gravida 5, whose previous pregnancies had been complicated by preeclampsia and "labile blood pressure" was seen early in pregnancy with a severe depression relative to this unplanned pregnancy. She requested abortion and was denied. She was referred for psychiatric consultation after several suicide threats and one questionably overt attempt at self destruction. Electroshock therapy was followed by "large doses" of tranquilizers. Six weeks prior to term her blood pressure had been noted at 150/100 and she had gained thirty pounds. According to the attending physician, "appropriate therapy" was instituted; at her next scheduled antepartum visit two weeks later, pressure was 120/76, but she had edema of her face and extremities. A three plus albuminuria was recorded, but microscopic examination of the urine was reportedly negative. She was placed on Esidrix 50 and Mysteclin, the latter for "possible urinary infection."

The evening prior to admission she called her physician to report a "bad headache," and her husband reported she was advised to take "a tranquilizer and an aspirin." This failed to relieve her complaints, so the patient repeated the medication in about two hours. Four hours later she awakened her husband with the statement that she could not see well and her head was "killing" her.

Since he was unable to contact the physician, the husband brought her to the hospital. In the emergency room the nurse called the supervisor to report that it appeared that the patient had "had a stroke." The physician was contacted via an unlisted phone and ordered an X-ray of the skull, 2 cc. 50% Mag. Sulfate I.M., tranquilizers, SMA 12 blood chemistry studies, and "check blood pressure every two hours."

Three hours and four phone calls later, the attending physician requested obstetrical consultation and came to see the patient. Five minutes later the consultant noted "twitching of the mouth," edema of the retina, "wire thin retinal arterioles," a left hemiplegia, blood pressure of 210/150, and 4 plus proteinuria. Questioning of the spouse elicited a history of a convulsion of short duration on the way to the hospital. Consultant advised ¼ grain Morphine Sulfate I.M., 50 cc. of 50% Glucose I.V. plus I.V. magnesium sulfate to be followed by 500 cc. 20% glucose, constant monitoring and indwelling catheter. At the completion of the I.V. Mag. Sulfate therapy, blood pressure was recorded at 160/90 and the laboratory reported a BUN of 30. Blood pressure remained reasonably stable in the 150/90 area and only 50 cc. of urine was passed in two hours. About one hour later the attending physician unsuccessfully attempted to do a lumbar

puncture. The consultant rechecked the patient, advised against repeat lumbar puncture, and that no further sedation be given the comatose patient save for control of reflex irritability by magnesium sulfate. He also advised no attempt at delivery until the patient was stabilized.

The attending physician noted evidence of pulmonary edema and "fearing the loss of two lives" began an induction with synthetic oxytocin. He also started nasal oxygen and intravenous diuretics (Diuril). A second obstetrical consultant concurred with the diagnosis of massive intracranial hemorrhage with evidence of toxemia, probably eclamptogenic. The patient at this time was completely unresponsive with cyanotic extremities and evidence of advancing pulmonary edema; 50 cc. of 50% Mannitol was given I.V. On vaginal examination the cervix was completely dilated with the head at a plus one station. Since damage from further induction attempts seemed unlikely, the fluids were not interrupted although they had not been originally advised by the consultant.

Delivery by outlet forceps of a stillborn fetus occurred two hours later and one hour after she began to crown, although fetal heart tones had been reported at 140 shortly before admission to the delivery room. Patient's temperature was 104, and she expired in the intensive care unit two hours later. Post mortem examination requested by nursing service was denied.

Discussion

Your committee felt the pressure of an unwanted pregnancy in an emotionally unstable patient whose death resulted as surely from obstetrical complications as it would have had her suicide attempt been successful. It was felt that her prenatal care had been adequate but not vigorous, and perhaps the recognition of her high risk potential would have prompted more vigorous efforts to prevent the development of toxemia. Unfortunately, this type of care is expensive and economic factors may have played a role. The use of tetracyclines in this patient was deplored on three bases: possible hepatic damage in the pregnant patient with symptoms of toxemia, and the possibility of pigmentation of the teeth of the infant, and the fact that the proteinuria was probably due to preeclampt toxemia rather than urinary infarction.

It seemed unfortunate that difficulty had ensued in impressing the attending physician of the potential dangers being expressed by the family the evening prior to admission and the hospital after admission. Then it seemed to your committee that the efforts to stimulate this patient to deliver vaginally were ill-advised. The possibility of increasing intracranial hemorrhage was apparently not considered; and the fact that a comatose patient cannot exert voluntary efforts to deliver herself seemingly was overlooked, else one hour of crowning during which time fetal heart tones were lost before forceps were applied would not have occurred.

Your committee was forced to accept this as a death due directly to obstetrical causes with preventable factors in the area of medical management and possibly in the area of sociology. ◄

Political Dropout?

Are you an American who does not bother to vote because you believe your vote won't make any difference?

One vote does make a difference. One vote per precinct over the nation in 1960 could have elected Nixon over Kennedy. A one precinct change in California in 1912 would have defeated Woodrow Wilson and made Charles Evans Hughes our President.

Many local elections, from governors to county commissioners, to sheriffs and lesser officers, often go as they do because one, two or three citizens in the affected districts or wards fail to vote.

If you are not sure whether you are registered, now is the time to find out. Now is the time, also, to learn where and how to apply for an absentee ballot if you may not be able to get to your poll on election day.

Absentee votes have swung elections. In 1940, at the close of election day, Payne Ratner, the Governor of Kansas, appeared to be defeated for reelection by 1,600 votes. But when the absentee ballots were counted, he was reelected by 430 votes.

In the United States, 47 million citizens failed to vote in 1968. This is more non-voters than the total electorates of such free nations as France, England, Italy, West Germany, Australia and Canada.

Who are these 47 million Americans who think so little of the inherent right cherished in other lands?

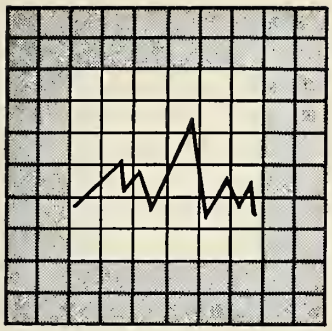
At least 15 million of these non-voters were qualified to vote, but just didn't bother.

About 10 million could have qualified by registering, but didn't.

Another 2 million were away from home, sick or disabled, but could have cast absentee ballots.

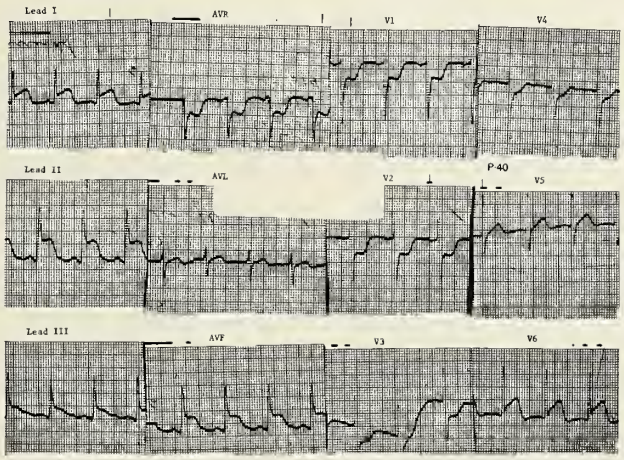
Don't be a political drop-out. Just by voting, you can be an important citizen in 1972.

Reference Issue Coming In October



ekg of the month

John R. Tobin, Jr., M.D., M.S., Rimgaudas Nemickas, M.D., Patrick Scanlon, M.D., John F. Moran, M.D. and James V. Talano, M.D./Section of Cardiology, Loyola University Stritch School of Medicine



A forty-six year old man entered the emergency room with a one hour history of severe left sided chest pain that radiated into his neck and left arm. He was diaphoretic and appeared ashen and confused. Physical examination demonstrated large dilated neck veins with both a and v waves, a small carotid arterial pulse, and bilateral medium crepitant rales in both lungs nearly to the top of the scapulae. His blood pressure was 80/50 and his pulse was 100 beats per minute with a thready character at the radius.

1. His electrocardiogram taken at the time shows:

A. Classic changes of pericarditis.

B. Changes compatible with electrolyte imbalance, probably potassium.

C. An injury current compatible with a large apical myocardial infarction.

D. An idioventricular rhythm.

2. The patient should be treated:

A. In the coronary care unit with continuous ECG monitoring.

B. With central venous and arterial pressure monitoring.

C. With fluids intravenously, digitalis parenterally and norepinepherine if the former therapy does not raise his blood pressure.

(Answer on page 254)

investment corner

The Split Real Estate Concept

By J. H. Smith, Jr., Account Supervisor
Harshe-Rotman & Druck, Inc.
108 N. State St., Chicago, 60602 (346-6868)

One real estate deal can be the right prescription for consistent, safe return-on-investment and for maximum tax shelter with a possible high future payout. The doctor may accomplish either or both goals in the same package.

Certain projects are now available on a split basis—that is, one limited partnership applying to the building complex, and thus sharing in the tax benefits of depreciation and interest on the mortgage, and one income partnership consisting of ownership of the land underneath.

Land in or near growing population centers has an intrinsic value, and its utilization for income-producing property adds to its productivity. It is the property, however, that furnishes the tax shelter.

For example: a $4 million, 216-unit residential complex, recently has been built on one of the most attractive acreages in exurban Chicagoland. The land is rented and the project has been split into two packages for investors.

In the first year of the building partnership, the limited partners (who invested $22,000 each) received a tax deduction equivalent to 71% of their investment. Investors in the 50% bracket can expect to recover their entire investment in about five years through tax savings and distribution of net operating revenues. There is a 6% tax-free cash flow to the building partner through 1977.

The land partners receive an 11% cash flow in ordinary income.

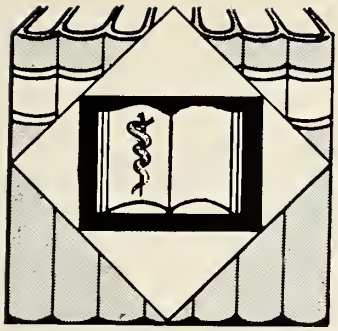
A similarly-handled, but less expensive project in the Chicago area is an office building for physicians. Some of the limited partners also are tenants.

An investment adviser who really understands real estate finance is the best source as to what real estate ventures are available for investment and which offer the building-land split feature. It is the nature of your investment objective that will determine which side of the split you should enter. ◄

Afraid to die

Burning one's driver's license would make a lot more sense than burning his draft card, if he is really afraid to die, gently suggests **Texas Medicine**, after stressing some comparative statistics.

These statistics not only point to 2,000 servicemen killed in combat in Vietnam in 1966 as contrasted with 7,000 servicemen dead in traffic accidents in the same year, but it contrasts the pick-up time of a few minutes by helicopter from the battlefield to be taken to a hospital staffed and equipped to meet every conceivable need, with the limited ambulance service and the inadequate hospital emergency rooms at home. ("And Every State Might Profit By The Survey," **J. Med. Assn. Ala.**, 39:11, May, 1970, p. 1015.)



the doctors library

THE CARE OF THE GERIATRIC PATIENT (fourth edition). Edited by E. V. Cowdry, Ph.D. and Franz U. Steinberg, M.D., 441 pages; C. V. Mosby Company, St. Louis, 1971; Price, $21.00

A prestigious collection of authors again have compiled what has become a standard review of geriatric medical and surgical care for the fourth time. Each chapter is written by a specialist in the particular field and this perhaps produces one of the weakest areas of the otherwise excellent volume. The actual care of the geriatric patient is most often accomplished by the "generalist geriatrician". The authors claim that, "the plan in writing this edition is for the internist to direct the medical care of geriatric patients in his own specialty and to refer them to specialists in other fields for advice on what they can do for the patients beyond the internist's limited capacity". It is felt that the limited specialist and his need for referral does not do justice to the needs of the elderly patient. Many of the medical problems of the elderly can, in fact, be very well handled by an experienced general geriatrician. The need for confident specialized geriatricians is in no way diminished, but it would probably be of greater benefit to the elderly patient if the specialist would refer the oldster back to the generalist for further care until such time as specialized care is again needed.

Each of the chapters is an excellent review of the current thinking which exudes through the individual authors. The chapter titled, "Hospitalization" reflects what must be an ideal situation at the Cedars-Sinai Medical Center in Los Angeles. The elderly person rarely experiences such excellent care in a general hospital as the chapter depicts.

An outstanding feature of the book is the chapter titled, "The Physician and the Patient" by Dr. E. V. Cowdry. Dr. Cowdry's chapter could not have been surpassed by a practicing geriatric physician. The clinical emphasis is prominent throughout the volume. The book is recommended for all who are concerned with the care of the geriatric patient.

Bertram B. Moss, M.D.

PEDIATRIC NEUROLOGY

The textbook, *Pediatric Neurology*, gives a general outline of neurological abnormalities in children. The first chapter of the book deals with the neurological examination of newborns and children and also gives an outline of the diagnostic studies utilized by the neurologist. In the chapter on epilepsy, one should note that the drug Tegretol has not been approved for seizures in the United States. In the chapters on the muscular diseases in infancy and childhood, one gets a basic foundation of these disorders. However, greater details, especially on adynamia episodica hereditaria, are not provided. The book also deals with cerebral palsy, mental retardation, headaches, congenital malformations, tumors, and neurological abnormalities seen in common pediatric problems.

The book is recommended for pediatricians as a general textbook. However, for pediatric neurologists, the information is not sufficiently detailed.

Marianne Larsen, M.D.

Having a Healthy Baby, Even with Heart Disease

A history of heart disease does not necessarily mean many women can not still have a safe pregnancy and a healthy baby, reports the Chicago Heart Association, 22 W. Madison St., Chicago 60602. It suggests that any such woman planning to start a family should get her doctor's approval first, and then follow the daily program he recommends for heart health.

"Your family doctor can help you go through pergnancy and childbirth without undue risk, and stay healthy during the months following pregnancy," the Heart Association says in their new booklet "Safeguarding Your Heart Through Pregnancy." The publication was prepared for young women with a history of heart disease, heart murmur or rheumatic fever.

It was prepared with the aid of Donald F. Leon, M.D., director of the cardiology division at Magee Women's Hospital, University of Pittsburgh.

The Recrudescence of Preventable Communicable Diseases

By Abraham Gelperin, M.D., Dr.P.H./Chicago

There are three categories of communicable diseases that reappear in spite of presumed satisfactory controls; those lurking in the environment, carried by vectors, and people-to-people communicants. Natural or man made disasters are causing explosive epidemics, such as Cholera in those areas of the world that have "primitive" water supplies and sewage disposal.[1] Recent outbreaks of water borne diseases emphasize that areas of the United States are not immune from embarassment.[2-4]

Potential and actual outbreaks transmitted by vectors are well known. The Rickettsia in the United States, and the malarial, filarial and bubonic diseases elsewhere are acknowledged to be ever present threats. Environmental and vector diseases may be dormant for many years, vary markedly in virulence, transmitted without harm to new generations of vectors, renewed by human and animal carriers, and temporarily interrupted in affecting people through sanitation services or vector control programs.

The list of preventable communicable diseases that are primarily transmitted by people to people is limited only by availability of reasonably effective and safe antigenic preparations. The same can be said for many of the diseases in the two categories mentioned above. However, outbreaks of environmental or vector based communicable diseases do not create the same reaction as an epidemic, no matter how small, of "controlled" diseases such as Rubella,[5] Diphtheria,[6-9] and poliomyelitis.[10] Recent outbreaks again demonstrate that detailed studies purporting to determine the reasons for the isolated reappearances of a "totally" preventable disease suggest that the natural history of these diseases, as well as the dynamics of the host-parasite relationship, are still immutable basics.

Control Programs

Subsequent to the initiation of intensive programs of immunization against Diphtheria by local and state health departments, with collaboration of practicing physicians during the late nineteen twenties, the morbidity and concommitant mortality from this disease declined markedly. However, this disease increased sharply during the mid 1930's in spite of a "well protected" preschool and school age population. Investigation of outbreaks provided answers to the questions raised about periodic, scattered mini-epidemics that continue to occur.[11-13]

It has been determined that a program of control of any communicable disease by immunization must be adjudicated in relation to its natural history. Has it had and continues to have cyclic reappearances due to an accumulation or influx of susceptibles, or variation in virulence of the parasite? Herd immunity is still a significant factor in protection of individuals through programs of mass immunization.[14] Do we have as many "poor reactors" as found years ago, children who do a poor job of self-protection upon stimulation by specific antigens?[15] There is continuing verification of the decline, in time, of immunity produced by immunization, and that some antigens are not

very antigenic.[16-18] Certainly, the incubation period of a disease is related to the possibility of its development in immunized persons.[19,20]

The socioeconomics of life, especially crowding, is acknowledged to be another major determinent.

Tuberculosis is a prime example of the effects of population density upon the incidence of infection. A study in Chicago during 1966-68 of the reactivity of the tuberculin test in 9th grade students in Chicago high schools, in the low socioeconomic areas, and schools in equivalent suburban Cook County areas, showed that the student groups in Chicago had positive rates as high as 45%, whereas students in communities just as poor but with markedly less crowding in Suburbia had positive rates around 5%.[21] To talk of tuberculosis in process of being under control is premature. The fundamentals of tuberculosis control is still acknowledged to be case finding as the basic, then case holding, continuity of proper therapy, examination of contacts, prophylactic therapy of positive tuberculin reactors, and BCG vaccination of specific high risk groups.

Man has helped eliminate various species of birds and animals from this earth, but to date none of the causes of disease. The host-parasite relationship, in particular, remains as a dynamic partnership that may cause disease or death of the host, or the suppression or elimination of a parasite in or with a host; but not yet the total demise of either, though both try at times. ◄

References

1. a. International Comments: "Cholera Invades Middle East." *J.A.M.A.* 213:2090, 1970.
 b. Your newspaper.
2. Borden, H. A., Harris, R. W., and Mosher, W. E.: "Waterborne Outbreak of Gastroenteritis in Western New York State," *Am. Jr. Pub. H.* 60:283, 1970.
3. A collaborative Report: "A Waterborne Epidemic of Salmonellosis in Riverside, California 1965." *Am. Jr. Epid.*, 93:33, 1971.
4. "One Hundred Nurses ill: back siphonage blamed," *Am. Soc. San. Eng. News Letter No. 11* (No. 511), March, 1963.
5. Chang, T., Des Rosers, S., and Weinstein, L.: "Clinical and Serologic Studies of an Outbreak of Rubella in a Vaccinated Population," *New Eng. Jr. Med.* 283:246, 1970.
6. Morbidity and Mortality Weekly Report: "Diphtheria, Florida, 1969, Jan. 31, 1970," Center for Dis. Control, Atlanta, Ga.
7. Morbidity and Mortality Weekly Report: "Follow-up Diphtheria Phoenix, Maricopa County, Arizona, Aug. 30, 1969," Center for Dis. Control, Atlanta, Ga.
8. Stewart, J. C.: "Analysis of the Diphtheria Outbreak in Austin, Texas 1967-1969," *Pub. H. Rep.* 85:949, 1970.
9. Nelson, K. E., Kallick, C. A., and Levin, S.: "Diphtheria in Chicago 1960-1970," *Ill. Med. Jr.* 139:35, 1971.
10. International Comments: "Has Polio Been Eliminated?" *J.A.M.A.* 213:1201, 1970.
11. Gelperin, A.: "A Recrudescense of Diphtheria," *Ohio St. Med. Jr.* 37:124, 1941.
12. Eller, C. H., and Frobisher, M.: "An Outbreak of Diphtheria in Baltimore," *Am. Jr. Hyg.* 42:179, 1945.
13. Brooks, G. F.: "Recent Trends in Diphtheria in the United States," *Jr. Inf. Dis.* 120:500, 1969.
14. Medical News: " 'Herd Immunity' theory Bolstered by Michigan Study," *J.A.M.A.* 210:1189, 1969.
15. Dudley, S. F., Mav, P. M., and O'Flynn, J. A.: "Active Immunization Against Diphtheria," H. M. Stat. Off., London, 1935.
16. Shelby, A. W., Herrmann, K. K., Alrutyn, E., Murphy, G. D., and Witte, J. J.: "Rubella Booster Immunization," *J.A.M.A.* 216:1451, 1971.
17. Medical News.: "Many Vaccines Appear to Have Low Antibody Levels," *J.A.M.A.* 215:286, 1971.
18. Supplement: "Collected Recommendations of the Public Health Service Advisory Committee on Immunization Practice," *Morb. and Mort.* Vol.. 18, No. 43. Oct. 25, 1969. Center for Dis. Control, Atlanta, Ga.
19. Sartwell, P. E.: "The Distribution of Incubation Periods of Infectious Diseases," *Am. Jr. Hyg.* 51:310, 1950.
20. Macleod, C. M.: "Relation of the Incubation Period and the Secondary Immune Response to Lasting Immunity to Infectious Diseases," *Jr. Imm.* 70:421, 1953.
21. Gelperin, A.: "A General Survey of Tuberculosis Facilities, Services, Programs and Problems in Metropolitan Chicago 1966-1968," Hospital Plan. Council of Met. Chicago, Illinois.



Abrahom Gelperin, M.D., is ossociote professor in the Deportment of Preventive Medicine ond Community Heolth, University of Illinois College of Medicine. He is o groduote of the University of Cincinnati Medical School and holds on M.S.H.A. from Northwestern University. Dr. Gelperin is o Planning Consultont to the Hospital Plonning Council of Metropoliton Chicago ond Medical Director of Ook Forest Hospitol. In oddition, o Dr.P.H. from Johns Hopkins School of Hygiene hos been token by Dr. Gelperin.

PKU Testing

One of every 100 patients in institutions for the mentally retarded has PKU. Every newborn child in Illinois is now tested for it. If not detected and treated the disease can cause mental retardation.

PKU, phenylketonuria, is a disease found in infants and very young children, and if they do not receive almost immediate dietary treatment it can cause irreversible brain damage. With a special diet, the mental retardation can be prevented or modified.

Since 1961 the Illinois Department of Public Health has had a program to combat PKU, but not until 1965 did the state Legislature make it mandatory that all children be tested for the disease.

Phenylketonuria is an inherited, abnormal condition characterized by phenylketones in the urine due to faulty metabolism of phenylalanine, an essential amino acid.

"Hot-Line" Crisis Counseling Service For Pregnant Women

By Eugene F. Diamond, M.D. and Rosemary Diamond, A.B./Chicago

The concept of crisis counseling by telephone has won widespread acceptance in recent years.[1] "Hot-line" type of emergency telephone counseling was first employed by suicide prevention centers and has been expanded to include similar services for drug addicts, alcoholics, juvenile runaways, compulsive gamblers, broken marriages, families with inadequate food, and other groups isolated and alienated in an urban society. It long has been recognized that the first twelve weeks of pregnancy are a crisis period for many women, particularly those involved in an unplanned or unwanted pregnancy.[2-5] In the age of the so-called "sexual revolution," this age-old problem has grown to frightening proportions as more and more women look for solutions to complex problems in available community resources.[6]

The first emergency telephone counseling service for pregnant women was established by Summerhill in Toronto, Canada, in 1968.[7] Since then, this crisis hot-line service known as Birthright has spread over North America to involve 28 states and 3 Canadian provinces.[8] This is a report of six months of experience in Birthright of Chicago, which functions out of two offices in the metropolitan Chicago area.

The method of operation in most Birthright centers is similar. Their service is advertised through "personal" columns of daily newspapers and student publications. The advertisement reads simply "Pregnant and distressed? call 233-0305." The telephones are answered in two offices in the southern and western areas of the metropolitan Chicago area. The person who answers the telephone is a Birthright volunteer. Since this is a woman-to-woman operation, only women are used as volunteers. Most are married women with families, but the entire age spectrum from students to grandmothers is represented. Prior to the establishment of the crisis center, all women were given approximately twelve hours of formal training from a faculty made up of obstetricians, psychiatrists, social workers, experts in drug abuse, agency representatives, and the personnel of other crisis telephone services. Additional on-the-job supervision is given during the first two months of service.

Method of Operation

Service is provided free-of-charge and with strict confidentiality. The need of the client is assessed and advice offered or referrals made to existing community agencies, the medical advisory board, cooperating hospitals, the legal advisory board, adoption center, maternity home, or other indicated facility. No attempt is made to replace existing agencies[9] in the community and no attempt is made to provide formal or extended counseling beyond the competence of the volunteers.[10] There is a medical advisory board consisting of forty physicians representing all medical specialties with obstetricians providing the greatest representation (25%). The legal

advisory board comprises nine attorneys and one judge.

When the offices are not occupied, a recorded message giving office hours and including an outline of services and words of encouragement and exhortation is provided through an automatic answering device.

Results

During the six month period from January 1, 1971 through June 30, 1971, approximately 3,500 calls were received at one or the other of the two offices; 1,739 of these callers actually discussed their problem, their interest, or their curiosity with a volunteer. Of these, 72 women required a formal medical referral to private practitioners and 24 were referred to clinics. Breakdown of medical referrals is shown in Table I.

Illustrative of the types of cases encountered are the following problems cited in the daily log of the Birthright offices:

1) A pregnant woman with rheumatic valvular disease alleged that she had been told by her family physician that she would "die if she became pregnant again." She was followed to term without serious complication by a cardiologist and an obstetrician.
2) A woman with history of post-partum depression was referred by her husband. Both spoke very little English. She was referred to a bilingual psychiatrist for care.
3) A gravida III mother who had one normal child and one with ataxia-telangiectasis was referred for genetic counseling.

The vast majority of callers had problems amenable to a single discussion with reassurance or with a referral to an existing agency or public assistance facility. A total of 494 non-medical contacts resulted in a need for multiple or extended contacts over a period of one week to six months. These are summarized in Table 2.

Since the principal function of the Birthright movement is to provide alternatives to abortion for pregnant women, no referrals to physicians or agencies counseling abortion were made. Of the 107 women requiring extensive anti-abortion counseling, none had medical, social, or financial problems which were insoluable by means other than abortion. All women required frequent contact for assistance during pregnancy and after the birth of the child. Medical care was

TABLE 1

MEDICAL REFERRALS

Obstetrical Care Only	47
Psychiatric Care	8
Drug Problems	7
Complicated Pregnancy	5
Cardiac Problems	3
Nephrolithiasis	1
Nephritis	1
Surgical Care	3
Genetic Counseling	2

TABLE 2

NON-MEDICAL PROBLEMS INVOLVING EXTENDED FOLLOW-UP

Legal Problems	13
Adoption Counseling	46
Personal Advice	241
Financial Assistance	71
Anti-abortion Counseling	107
Miscellaneous	16
Total	494

provided at no cost or at reduced rates where indicated. Cooperating hospitals provided care at reduced rates where the woman was not eligible for categorical assistance. Maternity wardrobes and layettes for the newborn were provided when needed. All babies offered for adoption were adoptable through either agency-assisted or private adoptions. In addition to the 107 women requiring long-term counseling, there were 162 additional calls from individuals seeking an abortion referral who terminated the contact when advised of the nature of the Birthright service. Of the total of 269 individuals calling about abortion, 141 were unwed, 57 were married women and 71 were males calling about pregnant wives or girl friends.[11]

The 107 women who accepted anti-abortion counseling were mainly women ambivalent about abortion who were being pressured by others toward an abortion decision.[12] Pressure came from "parents" (52), "husband" (11), "boyfriend" (34), "relatives" (4), "boss" (3) or "friends" (3).

Funding

All funds received came from private donations or small fund-raising events. No governmental assistance was received nor were monies

(Continued on page 256)

'Make Policy, Not Coffee'

By Mrs. Alan (Pam) Taylor/Danville
Auxiliary Representative to Governmental Affairs and IMPAC

In this exciting year, there is a button receiving widespread interest which says "Make Policy, Not Coffee." I would like to talk about this for a few minutes.

All of us have seen on our television screens this summer the greatly increased participation of women in the activities of both National Conventions. The Democratic Party has selected a woman as the National Chairman! Most observers of the political scene are predicting that women will have an ever greater impact on policy-making in the years to come.

The involved women that we watched on the television did not just spring full-blown into politics. They served an apprenticeship in their own community. Undoubtedly, they began as coffee-makers, not as policy-makers. How then did they advance? Let me suggest a few reasons which I'm sure were present in each one. First, they did such hard and non-glamorous jobs as holding coffees, working precincts, poll-watching, telephoning, speaking, addressing envelopes and handing out literature. They also persisted, whether they won or lost, whether the temperature was hot or cold, and whether they were criticized or not. They persisted because they believed in what they were doing.

No doubt, they learned as much as possible about politics and government. They read, went to meetings, and were not afraid to ask the "dumb" question.

They knew when to be patient and when to be impatient. Now, all of us cannot be a National Chairman (and few of us would want the job), but we probably would like the opportunity to make policy, not coffee; and we would rather make it at the local level than anywhere else.

It is at the local level, where our children go to school, where our home is, and where the services that are important to us are located.

Through our Auxiliary, and through Illinois Medical Political Action Committee (IMPAC), we can help you enhance your role as an active and intelligent woman in a rapidly changing society which is making way for the active and informed woman.

Specifically, we can provide you with nonpartisan information about your government at the local, state and national levels. This may be candidates, issues and referenda. Does your county have the question of retaining the Coroner on the ballot? Is your county holding a health department referendum or one on mental health?

Do you want to work for a candidate? If so, we can provide some guidance, some materials and some contacts.

Are you concerned about issues which may be determined next year by those who are elected in November? What about abortion, alcoholism, drug control, health delivery systems, licensing, mental health? If so, we can provide materials, speakers and, hopefully, answer your questions.

What I am trying to communicate is that 1972 is a tremendously exciting and important year and there are many opportunities which are available. Shall we make the most of them?

Have we in the Auxiliary spent too much time in frivolous social programs and not enough on those activities that are significant? While we have been concerning ourselves with "making coffee and flower arrangements," have other women been making policy?

It is important to realize that one woman, armed with determination and knowledge, can do a great deal. That which is done in a political campaign has the advantage of having a lasting value. A candidate that you help to elect serves for two, four or six years and can accomplish a great deal in that term. A referendum which provides for a county health department will be providing benefits to people for years to come.

There is also the personal satisfaction that comes from participation. You have proven that you could do a job and make a distinct contribution—even when the ground was unfamiliar. You may have made some mistakes, but you have found that politics can be fun too.

You should also realize that you have set an example to your children, friends, and community. By your example, you have made it easier for other women to participate; and without participation our representative form of government would have no meaning.

I firmly believe that we women have a special contribution to make to government and that we must start now.

Some years ago, I got involved in political campaigns and in one election, I was in charge of the telephone campaign on behalf of a State Senator. He was elected and it is no surprise to find that he is quite attentive to my views on medical legislation. In other words, I now help make policy in the Illinois Senate and if I can do it, so can you.

Let me wind up with a few comments about IMPAC (Illinois Medical Political Action Committee). I serve on its Board and I can assure everyone that it acts in a very nonpartisan manner. Membership is $25 for the physician and $20 for his wife. This also includes membership in AMPAC (American Medical Political Action Committee). When we consider that the dues to the Welfare Right Organization by women on public aid is $13, we can see that the IMPAC-AMPAC membership is quite low.

This money is used to pool campaign contributions from throughout the State and then to distribute them to deserving candidates of both parties. We help the candidates when they need it most. We recognize the fact that they cannot be good legislators unless they are elected. We are not buying votes, but we are registering our support in a way that will not be forgotten. IMPAC also acts very prudently and money is not wasted in lost causes.

If you and your husband are not already a member of IMPAC, I would suggest that, right now, you make out a check for $45 and send it to the IMPAC office at 360 N. Michigan Ave., Chicago 60601. If he is a member, and you are not, then send a check for $20, and do it today.

Also, let me know if there is anything that we can do to help you get involved so that you can be making policy, not coffee.

Auxiliary Presidents-Elect Attend "Big Cities Clinic"



Gathered in Chicago this winter far the national Auxiliary's "Big Cities Clinic" were (left ta right): Mrs. Steven J. Carlisle, president-elect of Multnamah Caunty, Ore., Auxiliary; Mrs. Willard C. Scrivner, national first vice president from East St. Lauis, Ill.; Mrs. John L. Fax, president-elect of the District af Columbia Auxiliary; Mrs. G. Prentiss Lee, national president from Portland; Mrs. Robert F. Beckley, national president-elect from Lack Haven, Pa.; and Mrs. Gerald D. Dorman, New Yark State members-at-large chairman. Mrs. Scrivner was elected national president-elect at the June meeting.

The meeting provided Auxiliary members an appartunity to discuss problems and offer salutions to membership difficulties affecting large cities.

Ed. Note

PULSE will not appear in October, since it is the Reference Issue of IMJ.

what goes on

a guide to continuing education

September 25-27—Children's Memorial Hospital

Three-day postgraduate course "Problem in Pediatric Cardiology"

This course will be under the direction of Dr. Alexander S. Nadas and his associates in the Department of Cardiology.
Contact: Children's Memorial Hospital Medical Center, 300 Longwood Avenue, Boston, MA 02115 (617) 734-6000

Children's Memorial Hospital, Boston, MA

October 2—American Society of Anesthesiologists

Nurse Symposium

This symposium will be of special interest to nurse anesthetists. It begins at 9:00 a.m. As in the past two years in which this symposium has been scheduled, the program promises to be interesting and stimulating.
Contact: American Society of Anesthesiologists, 515 Busse Highway, Park Ridge, IL. 60068.

Commonwealth Room of the Sheraton Hotel, Boston, MA.

October 2-4—The American College of Physicians

Postgraduate Course "Current Concepts in Hematology"

The purpose of this course is to give specialists in internal medicine and related specialties an opportunity to review basic information and to find out what's new in a particular area of interest. The course consists of a series of formal presentations covering aspects of new knowledge in appropriate blood disease areas and their application to clinical hematology. The course is designed to serve as a review for those taking subspecialty examinations in hematology.
Contact: Edward C. Rosenow, Jr. M.D. Executive Vice President, American College of Physicians, 4200 Pine Street, Philadelphia, PA 19104

University of Pittsburgh School of Medicine, Pittsburgh, PA

October 4-5—Medical Center and Extension Division of the University of Missouri

Conference on Child Development and Child Psychiatry in Missouri

A two-day conference on child development and child psychiatry will be held. It is directed to professionals working with children who have adjustment problems. It will cover aspects of personality development related to early experiences as well as to possible biologic contributions.
Contact: Bettye Caldwell, Director, Center for Early Development, University of Arkansas.

University of Missouri Medical Center, Columbia, MO

October 9-11—American Electroencephalographic Society

"Clinical Electroencephalography"

The course is designed to review the fundamentals and principal applications of electroencephalography to clinical medical practice. A distinguished faculty will present the material, whose expanded curriculum will include time for individual interpretation sessions and closed circuit TV demonstrations.
Contact: Dr. Donald W. Klass, EEG Course Director, Mayo Clinic, Rochester, MN 55901.

October 11—The University of Chicago

"Frontiers of Medicine"
Recent Progress in the Management of the Complications of Streptococcal Infections

The program consists of nine monthly sessions, the first of which will be on October 11. There is one a month. A few of the topics are, November 8: "Virology in Medicine," January 10: "Advances in Coronary Heart Disease," and May 9: "The Acutely Injured Patient."
Registration Fee: $100 for the series and $15 for a single session.
Contact: Frontiers of Medicine, Room 404, Culver Hall, The University of Chicago, Chicago, IL 60637

Lecture Room P-117 (The Frank Billings Auditorium) Chicago, IL

(Continued on page 253)

Abstracts of Board Actions

(Continued from page 183)

gates, especially the segment pertaining to student memberships. The local Societies will be asked to bring their membership provisions in line with ISMS bylaws.

Membership In Affiliated Groups

Upon recommendation of the Executive Committee, the Board voted to renew ISMS membership in the Illinois Council of Voluntary Health Agencies, requesting the Council on Public Relations assign a representative to attend all meetings of the organization. An invitation to join the American Association for Comprehensive Health Planning was declined.

ISMS will renew its support of the Citizens Alliance for VD Awareness, a privately funded organization with which the Council on Environmental and Community Health has maintained liaison, and the Interagency Committee on Smoking and Disease.

Laboratory Proficiency Testing

Having previously referred to the Council on Environmental and Community Health, a request from the Illinois Department of Public Health to cooperate on a survey of physician's office laboratories, the Board accepted the council's recommendation that ISMS work with IDPH in developing this survey. Purpose is to determine which practicing physicians are performing clinical laboratory services in the office and to ask those identified to subscribe to proficiency testing.

Ambulance Service In Illinois

ISMS will urge that any legislation designed to improve ambulance services in Illinois include sufficient financial aid to prevent destruction of the existing system. The Board formally recognized the positive contribution now being made to the health care delivery system by these ambulance services, especially in rural areas, and will seek to preserve the system until the new trauma network is fully implemented on a statewide basis.

Emergency Mobile Intensive Care Personnel

ISMS will offer assistance in the development of a pilot program utilizing mobile intensive care personnel for the delivery of emergency medical care to the sick and injured during transport to a hospital, while in the hospital emergency department and until care and responsibility can be assumed by the regular hospital staff. Enabling legislation, instigated by a suburban Chicago woman, has been passed as SB 1571, and the program will be tied in with the statewide trauma program.

An ad hoc committee on Emergency and Disaster Care was appointed to work with the Department of Public Health to insure that adequate educational training standards are established and enforced before personnel are certified by the department. The committee has been directed to consult with the ISMS Council on Education and Manpower regarding training. The Board will formally request that ISMS be given the opportunity to work with the Public Health Department in developing the program before the rules and regulations regarding SB 1571 are promulgated.

Physicians' Right to Bill for Services

The Board endorsed the principle that Medicaid should pay physicians for medical services rendered in conjunction with a teaching program in addition to any hospital charges as Medicare does. The Board said that when a physician treats patients in a teaching institution and when these services are separate and apart from the educational aspect of his job, he has the right to bill for these services.

Accreditation of Continuing Medical Education

Because the AMA is no longer able to evaluate all the continuing medical education programs being conducted for credit, it has requested that state medical societies assume this responsibility. ISMS will begin a program of accrediting community hospital continuing education activities, as soon as the Council on Education and Manpower develops procedures and they are approved by the AMA.

Congress on Rural Health

The Board approved in principle five recommendations developed by the AMA Congress on Rural Health. These recommendations include representation by local medical societies in "B" agency Comprehensive Health Planning; development of better relationships with specific consumer groups; working with Illinois Hospital Association to help rural hospitals; assisting health science schools in producing primary health care personnel under the Health Manpower Act, and promoting increased emphasis on health education in the schools.

Distribution of Action Report

Action Report, which was initially mailed to all ISMS members and is now only sent to those who returned cards requesting that they continue to receive it, will return to full-member mailing periodically as revenue allows.

HASP Information Program

Believing that there are still many ISMS members who do not fully understand the HASP program, the Council on Public Relations has requested authority to conduct a full-scale information program on this subject. The Board concurred.

Invitations to Annual Meeting

The Joint Management Committee for the annual convention and the Board of Trustees have agreed that non-ISMS physician groups, including osteopaths, should be encouraged to participate in the meeting.

Legislator Interview Program for TV

The Board approved a request from the Public Relations Council that money be included in next year's budget to resume the project conducted in 1971 whereby key members of the legislature were interviewed on film, which was then sent to their home town areas. The project was considered highly successful last year, but not continued in 1972.

Comprehensive Health Planning and Regional Medical Programs

The Board has authorized the Council on Economics and Peer Review to act as a committee of the whole to fulfill its assigned duties as liaison with Comprehensive Health Planning and the Illinois Regional Medical Program, as well as to obtain information and evaluate the new modes of health care delivery being proposed in the state. The council plans to accomplish these tasks by establishing ongoing relations with representatives from CHP and IRMP and with spokesmen from the proposed health care delivery programs (HMOs and prepaid plans). These representatives will be invited to future council meetings. The Council will also function as liaison with Medicare and Medicaid.

Medical Care for Children in Foster Homes

The question of adequate medical care for children in foster homes was referred by the Board to the Illinois Department of Public Aid's Medical Advisory Committee.

Government Programs Workshop for Medical Assistants

The Board approved in principle ISMS sponsorship of workshops for medical assistants to acquaint them with the paper work involved in government health care programs. Financial contribution should not be expected from ISMS and if insurance companies are asked to support these programs, the Board directed that this should be done on an equitable basis. A registration fee was suggested.

Sickle Cell Disease

The Council on Environmental and Community Health has been directed to investigate misleading implications and rumors about sickle cell anemia and sickle cell trait and to support a sound educational program. ◄

Twenty Nine Clinics for Crippled Children

Twenty nine clinics for Illinois' physically handicapped children have been scheduled for October by the University of Illinois, Division of Services for Crippled Children. The Division will count twenty-two general clinics providing diagnostic orthopedic, pediatric, speech and hearing examination along with medical social, and nursing services. There will be five special clinics for children with cardiac conditions, and two for children with cerebral palsy. Any private physician may refer to or bring to a convenient clinic any child or children for whom he may want examination or consultative services.

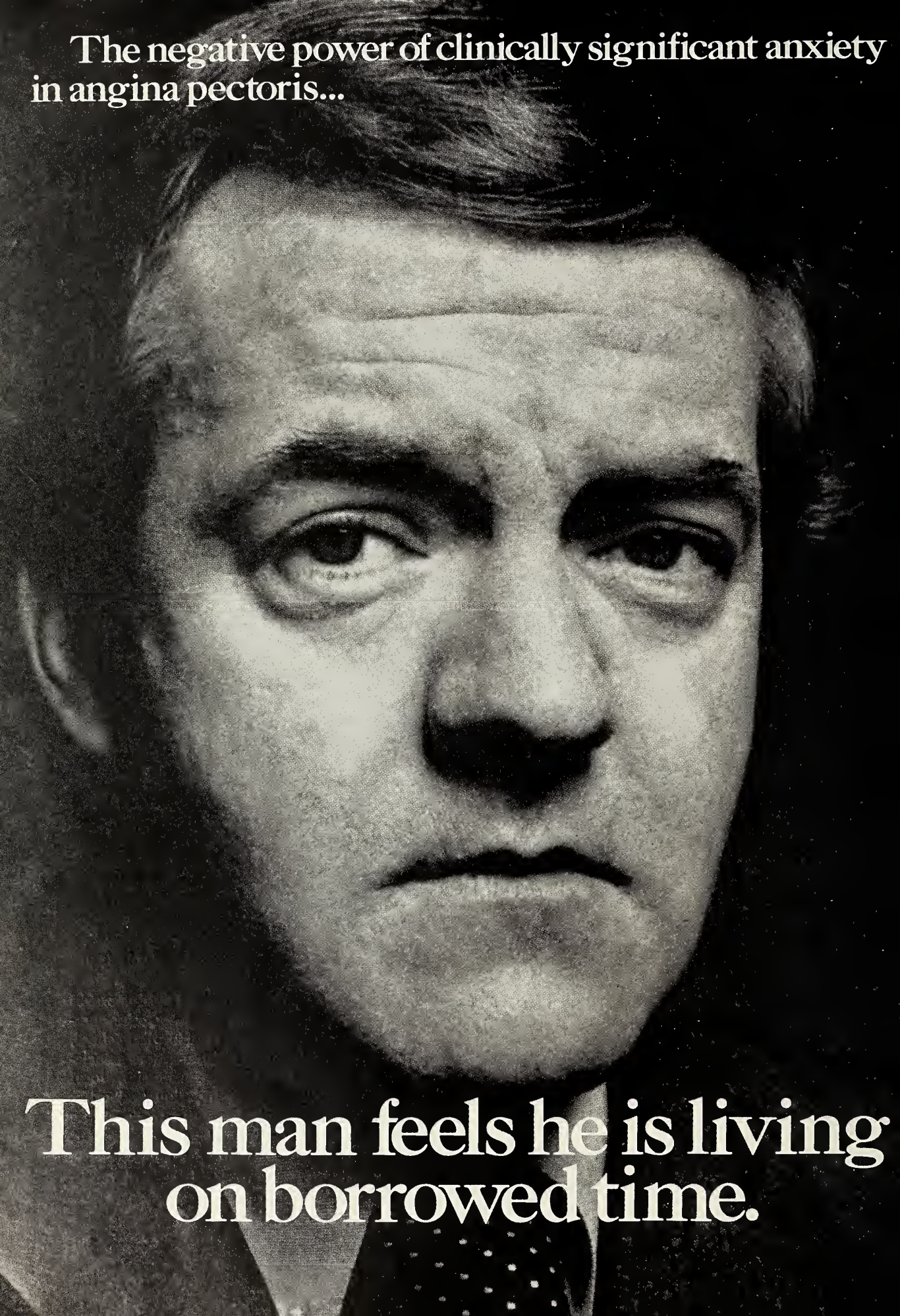
October

3 Quincy—St. Mary's Hospital
4 Hinsdale—Hinsdale Sanitarium
4 Rock Island Cerebral Palsy—Foundation for Crippled Children and Adults
4 Metropolis—Massac Memorial Hospital
5 Sterling—Sterling Community Hospital
5 Lake County Cardiac—Victory Memorial Hospital
5 Flora—Clay County Hospital
5 Cairo—Public Health Department
10 Peoria—St. Francis Hospital
10 Carrollton—Boyd Memorial Hospital
10 E. St. Louis—Christian Welfare Hospital
11 Champaign-Urbana—McKinley Hospital
12 Springfield—St. John's Hospital
13 Chicago Heights Cardiac—St. James Hospital
16 Peoria Cardiac—St. Francis Hospital
17 Rock Island Area General-Moline Public Hospital
18 Chicago Heights—St. James Hospital
19 Elmhurst Cardiac—Memorial Hospital of DuPage County
19 Bloomington—Mennonite Hospital
19 Rockford—St. Anthony Hospital
24 Peoria—St. Francis Hospital
24 Danville—Lake View Hospital
25 Aurora—St. Joseph Mercy Hospital
25 Springfield Pediatric Neurological—Diocesan Center
25 Centralia—St. Mary's Hospital
25 Mt. Vernon—Park Avenue Baptist Church
27 Chicago Heights Cardiac—St. James Hospital
27 Evanston—St. Francis Hospital
31 E. St. Louis—Christian Welfare Hospital

The Division of Services for Crippled Children is the official state agency established to provide medical, surgical, corrective, and other services and facilities for diagnosis, hospitalization and after-care for children with crippling conditions or who are suffering from conditions that may lead to crippling.

In carrying on its program, the Division works cooperatively with local medical societies, hospitals, the Illinois Children's Hospital-School, civic and fraternal clubs, visiting nurse association, local social and welfare agencies, local chapters of the National Foundation and other interested groups. In all cases the work of the Division is intended to extend and supplement, not supplant activities of other agencies, either public or private, state or local, carried on in behalf of crippled children.

The negative power of clinically significant anxiety in angina pectoris...



This man feels he is living on borrowed time.

During anginal attacks, patients may suffer intense apprehension. More frequently, however, they experience a continuing sense of less severe but nonetheless disproportionate anxiety.

Reduction of such clinically significant anxiety is important, since undue emotional stress may precipitate further anginal episodes.

Adjunctive Librium (chlordiazepoxide HCl) may be especially suitable for relief of clinically significant anxiety and emotional tension in anginal patients because of its generally prompt therapeutic effectiveness and wide margin of safety. In a recent double-blind randomized study,* Librium (chlordiazepoxide HCl) was administered for relief of moderate anxiety in 20 anginal patients seen in office practice over a 20-week period. Symptoms of emotional distress related to anxiety were rated at base-line, one week, two weeks and monthly thereafter. Relief was obtained notably early in therapy. The clinical results demonstrated that Librium offers the coronary patient an antianxiety drug that, in the author's opinion, is both effective and safe. In general use, the most common side effects reported have been drowsiness, ataxia and confusion, particularly in the elderly and debilitated. (See summary of prescribing information.)

Librium (chlordiazepoxide HCl) is used concomitantly with certain specific medications of other classes of drugs, such as cardiac glycosides, diuretics and antihypertensive agents, whenever anxiety is clinically significant. The drug should be discontinued after anxiety has been reduced to appropriate levels.

The positive power of adjunctive Librium® (chlordiazepoxide HCl)

10-mg, 25-mg capsules up to 100 mg daily

for moderate to severe anxiety accompanying angina pectoris

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Relief of anxiety and tension occurring alone or accompanying various disease states.

Contraindications: Patients with known hypersensitivity to the drug.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. As with all CNS-acting drugs, caution patients against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported. Use of any drug in pregnancy, lactation, or in women of childbearing age requires that its potential benefits be weighed against its possible hazards.

Precautions: In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (*e.g.*, excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

Adverse Reactions: Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.

Supplied: Librium® Capsules containing 5 mg, 10 mg or 25 mg chlordiazepoxide HCl. Libritabs® Tablets containing 5 mg, 10 mg or 25 mg chlordiazepoxide.

*Levine, S.: "Angina Pectoris and Emotional Overlay," Scientific Exhibit presented at the Annual Meeting of the Maine Medical Association, Kennebunkport, Me., June 13-15, 1971.

A copy of the Levine study may be obtained from your Roche representative.

ROCHE

Roche Laboratories
Division of Hoffmann-La Roche Inc.
Nutley, N.J. 07110



report

a service of the american association of medical assistants, illinois society

Prevent Paper Work Pile Ups

Are your assistants keeping in step with the paper work changes of your busy practice? Paper work can be a headache—especially if office procedures are confusing. And delayed filing of claims means delayed payments.

As a help to you and your assistants, the Illinois State Medical Society and the American Association of Medical Assistants, Illinois Society, have planned a series of workshops to help eliminate the troubles of Medicare and Medicaid claims. Problems can be prevented if assistants know correct procedures. Thus, we have arranged to have J. M. Kilbreth, Medical Administration Office, Illinois Department of Public Aid and Charles Pless, supervisor, Program Integrity, Medicare Division of Continental Casualty Company to tour the state to bring this information to your assistants.

These programs are being held in conjunction with the Illinois State Medical Society President's Tour. The dates and sites are as follows:

October 10
Elks Club, Moline
7:30 to 9:30 p.m.

October 16
Quincy, Illinois
7:30 to 9:30 p.m.

November 13
Gateway Inn, Harrisburg
7:30 to 9:30 p.m.

February 13, '73
Henrici's, Rockford
7:30 to 9:30 p.m.

Both representatives will explain the procedures used in processing claims once they reach their offices. They will also outline the situations that create delays in payments and the methods your assistant can use to avoid them.

Have your assistant jot down her questions concerning these governmental programs. A question and answer period will follow each speaker.

Members of the AAMA, Illinois Society will be on hand to make your assistants welcome. AAMA is a non-union, educational organization endorsed by the AMA and the ISMS. Its primary purpose is to help your assistants increase their knowledge, making them better qualified to assist both you and your patients.

Encourage your assistants to attend the workshop nearest you. The benefits will be evident as she develops a greater understanding of these two governmental programs.

Inquires about these programs can be directed to the Illinois State Medical Society office or to Mrs. June Hall, president, AAMA, Illinois Society; 1217 Sheridan St., Danville, IL 61832. ◄

caring better for her basic needs,
less confused in her thinking; no great
accomplishment for most people, but a
significant advance for the arteriosclerotic
patient with cerebrovascular insufficiency

Hydergine®

SUBLINGUAL TABLETS containing 0.167 mg. dihydroergocornine methanesulfonate, 0.167 mg. dihydroergocristine methanesulfonate, and 0.167 mg. dihydroergokryptine methanesulfonate

helps patients with cerebrovascular
insufficiency due to arteriosclerosis
do little things better

The usual dosage is four to six sublingual tablets daily. The patient's improvement with Hydergine is usually demonstrated in four to six weeks. Some nasal stuffiness due to adrenergic blockade, transient nausea or gastric disturbances have been reported with high dosages.

71-190R

SANDOZ PHARMACEUTICALS, EAST HANOVER, N.J. 07936 SANDOZ



new pharmaceutical specialties

by paul dehaen

For detailed information regarding indications, dosage, contraindications and adverse reactions; refer to the manufacturer's package insert or brochure.

Single Chemicals: Drugs not previously known, including new salts.

Duplicate Single Products: Drugs marketed by more than one manufacturer.

Combination Products: Drugs consisting of two or more active ingredients.

New Dosage Forms: Of a previously introduced product.

The following new drugs have been marketed:

DUPLICATE SINGLE PRODUCTS

PSP-IV: Corticoids ℞
Manufacturer: Tutag
Nonproprietary Name: Prednisolone Sodium Phosphate
Indications: Conditions responding to parenteral corticoid therapy.
Caution: Tuberculosis, ocular herpex simplex and acute psychosis.
Dosage: Must be individualized
Supplied: 10 cc, multiple dose vial

COMBINATION PRODUCTS

DIPLOVAX: Biologicals ℞
Manufacturer: Pfizer
Composition: Each dose of trivalent Poliovirus vaccine, live, oral, contains:

Type 1	800,000 $TCID_{50}$
Type 2	100,000 $TCID_{50}$
Type 3	500,000 $TCID_{50}$

Indications: Vaccination against poliomyelitis
Supplied: 0.5 cc —10 one-dose vial
10 dose vial

ESCOT: Antacids o-t-c
Manufacturer: Tutag
Composition: Bismuth aluminate 100 mg.
Magnesium trisilicate 100 mg.
Aluminum hydroxide 200 mg.
Magnesium carbonate 200 mg.
Indications: Adjunctive treatment of peptic and duodenal ulcer.
Dosage: 1 or 2 capsules 3 or 4 times daily
Supplied: Capsules

RECOUP: Hematinics o-t-c
Manufacturer: Lederle
Composition: Elemental Iron (as Ferrous Fumarate 150 mg.) 50 mg.
Vitamin C 300 mg.
Dioctyl Sodium Sulfosuccinate 50 mg.
Indications: Simple iron-deficiency anemia
Dosage: Severe disorders—1 tablet twice daily
Simple forms and maintenance—1 tablet daily
Supplied: Tablets

NEW DOSAGE FORMS

ARISTOSPAN: Corticoids ℞
Manufacturer: Lederle
Nonproprietary Name: Triamcinolone Hexacetonide
Indications: Dermatologic lesions responding to intralesional corticosteroids.
Caution: Do not give intravenously. Usual interdiction of corticoid therapy.
Dosage: Up to 0.5 mg. per square inch of affected skin. Inject intralesionally or sublesionally.
Supplied: 5 cc.—12 cc. vial, may be diluted.

NEO-QUINETTE: Antiinfectives-Vaginal ℞
Manufacturer: Arnar-Stone
Composition: Diiodohydroxyquin 100 mg.
Sulfadiazine 500 mg.
Indications: Vaginal infections caused by susceptible organism.
Caution: Iodine intolerance, liver and kidney damage. Topical sensitivity to sulfonamides.
Dosage: 4 gm. of cream (½ applicator). Insert high in posterior fornix upon retiring.
Supplied: 96 gm. tube with applicator

NILSTAT: Fungicides-Topical ℞
Manufacturer: Lederle
Nonproprietary Name: Nystatin
Indications: Cutaneous or mucocutaneous monilial infections.
Caution: Hypersensitivity to Nystatin
Dosage: Apply liberally to affected areas twice daily.
Supplied: Cream: 100,000 U/gm.
Tubes, 15 gm.

(Continued on page 252)



The combination contraceptive that is virtually without side effects

Together, ORTHO* Diaphragm and ORTHO-GYNOL* Contraceptive Jelly offer advantages that are worth considering:

1. high level of effectiveness
2. no problem with adverse reactions
3. control remains with the woman
4. virtually no loss of sensation
5. used only as needed

...and *no* other form of contraception offers *all* those advantages.

To these, Ortho adds convenience for the patient:

The Ortho Diaphragm Kit, which includes an Ortho Diaphragm (ALL-FLEX* Arcing Spring, Coil Spring, or Flat Spring), a tube of Ortho-Gynol Contraceptive Jelly, and an illustrated instruction book.

For the physician:

Professional fitting-ring set and fitting-procedure brochure available. See your Ortho Representative.

ORTHO PHARMACEUTICAL CORPORATION · RARITAN, NEW JERSEY 08869

Ortho

*TRADEMARK
©OPC 1972

Christian Fenger

He liked a good cigar after dinner and he enjoyed a glass of good wine. California claret and champagne were to him a part of the menu. But, as for the American whiskey in the closet or bar-room drinking he could not say enough in condemnation. He believed wine should be a part of any well ordered dinner or luncheon and was convinced that there would be much less drunkenness were the young people taught at home to drink the right kind at the right time in moderate quantity. Certain it is that his own son was allowed to drink a small glass of wine at dinner from his 14th or 15th year, and I do not believe that he has ever had a desire for more than was quite good for him. And those were the days of a very moderate price for California wines though the cost was always much more than that of a superior wine in Europe. He loved a well cooked dinner and during the first years of our married life it was my greatest care to learn to prepare dishes he liked. He put marks under the different things he liked in the index of the Danish cook-book, and I struggled with innumerable messes until I reached a passable ability, knowing well it was often no delicacy that I set before him. Yet never did he fail to praise my efforts. I had never really learned anything and had seen less, and when I think back on those early years I wonder and marvel at his endless patience and love and feel keenly how very ignorant and unworthy I was. He had seen and enjoyed the best the world had to give, yet here he was working very hard without vacation or recreation for many years. (Caroline Fenger's Biography of Her Husband. **The Proceedings of The Institute of Medicine of Chicago.** 29:2 [Mar.] 1972, pgs. 53-60.)

ANOTHER ISMS MEMBERSHIP PRIVILEGE

LOW-COST GROUP INSURANCE

GROUP DISABILITY PLAN

- **NEW**—Guaranteed renewable feature
- Sickness benefits to age 65
- Up to $250.00 weekly benefits

(PROTECT YOUR INCOME AND SECURITY)

GROUP SUPER MAJOR MEDICAL PLAN

- Up to $50.00 daily room and board
- Up to $25,000 for each accident or sickness
- In hospital and out of hospital expenses

(TRULY CATASTROPHIC PROTECTION)

FOR INFORMATION, ASSISTANCE & DETAILS CONTACT:

Administrators:

PARKER, ALESHIRE & COMPANY
ESTABLISHED 1901
Insurance

9933 N. Lawler Avenue
Skokie, Illinois 60076
Phone: 312-679-1000

Doctor's News

ILLINOIS PHYSICIANS CUT HOSPITAL COSTS—"Illinois physicians are six months along on a plan similar to one proposed in August by the American Hospital Association to establish guidelines to cut soaring hospital costs," declares Dr. Joseph R. O'Donnell, president of the Illinois Foundation for Medical Care. This was in response to an announcement by the AHA of an upcoming national program that places responsibility on physicians for "keeping costs down in hospitals while boosting health care."

Dr. O'Donnell was referring to the unique hospital-monitoring project—the Hospital Admission and Surveillance Program (HASP), created by IFMC, an organization formed by the Illinois State Medical Society.

"HASP's objective is the same as that of AHA's proposed program—to reduce length of hospital stays without sacrificing the quality of medical care," Dr. O'Donnel said. "In effect for more than six months, it has been limited to Medicaid patients, but has the potential for expansion to general patients in all of the state's hospitals."

Dr. O'Donnell and Dr. Frank J. Jirka, Jr., ISMS president and chairman of IFMC's policy-making state HASP committee, said that the project already is a "proved success" with average length of hospital stay now only 5.7 days for 44,000 certified patients in 231 hospitals throughout the state. They pointed out that in community hospitals nationally last year, the average length of stay was eight days.

While the average hospital stay was 5.7 days during the six-month period, longer stays may be requested by the attending physician if medically necessary.

"It all adds up to an efficient and effective system of checks and balances," Dr. Jirka explained, "and the end result is that the patient stays in the hospital as long as medically necessary, but no longer." Dr. Jirka stressed the fact that savings are being effected by HASP without sacrificing quality, the first consideration of physicians.

In addition HASP will: 1) increase cooperation between doctors and hospital administrators; 2) maximize the efficiency of a hospital stay; 3) place greater emphasis on out-patient treatment when medically sound; 4) use recognized medical standards to establish specific length of hospital stays for various illneses; and 5) establish through advance planning the type of nursing home care a patient may need.

ISMS PRESIDENT'S TOUR FOR OCTOBER:—Dr. Frank Jirka will be speaking in the following society counties during October:

October 10—Rock Island—Rock Island Rotary Club, at the Elks Club in Moline

October 12—LaSalle—Holiday Inn in Peru

October 16—Adams—Quincy Kiwanis Club, at the Holiday Inn in Quincy

SMALLPOX LAW CHANGED—A new law amending the School Code has removed smallpox from the list of communicable diseases for which Illinois children are required to be immunized. The School Code has also been amended to provide for a sickle cell anemia test, to be administered by request of the examining physician when he determines it necessary.

EAR PIERCING—The Illinois Department of Registration and Education has recently reaffirmed its position that ear piercing is a surgical procedure and can only be done by a physician. This was brought to light again when the Department began to issue a "cease and desist" orders to non-physicians piercing ears in department stores in Chicago.

R & E CIRCULATING REGISTRATION CARDS—By mid-September The Department of Registration and Education will circulate a letter and registration card to all licensed physicians in Illinois. This is in compliance with Section 301 of the Illinois Controlled Substances Act of 1971. By this, R & E is to "register" every person engaged in manufacturing, distributing, or dispensing of controlled substances. The card will ask for currently valid B.N.D.D. numbers, and ask physicians to indicate the controlled substances schedule for which they would like to be registered. This is a matter of registration, and no fee will be required.

Physicians are urged to check all schedules, II through V, to insure that they will be allowed to prescribe or dispense any controlled substance. Action by R & E will not require any additional inventory control since federal regulations already dictate inventory procedures. After this initial registration, doctors will be registered at the time of license renewal.

The definition of a "dispenser," according to R & E, includes physicians and others lawfully permitted to distribute, dispense, administer or use controlled substances in the course of professional practice. Merely filling out the card will effect registration.

TWO CHICAGO HOSPITALS MERGE—The boards of Chicago Wesley Memorial and Passavant Memorial Hospitals voted August 14 to merge under the new name of Northwestern Memorial Hospital. Operation of the new hospital began September 1. Both institutions are teaching-hospitals affiliated with Northwestern University-McGaw Medical Center.

Northwestern Memorial will be the largest private hospital in Illinois with 993 beds, and the sixth largest private facility in the country. There will be a 450-member medical staff, 2,543 employees and a 79 member board of trustees.

NU MEDICAL SCHOOL CHANGES TRAINING—Northwestern University Medical School will introduce a system of graduate education that may foreshadow a change in intern and residency training throughout the nation. Under the existing arrangement each hospital competes for graduate medical trainees. In the new program, hospital representatives will act jointly with the medical school to recruit trainees and design and evaluate training. Trainees will be rotated through the Northwestern University-McGaw Medical Center hospitals, and exposed to a variety of patient populations and medical faculty. Five hundred and fifty interns and residents will be affected.

TRAUMA NETWORK RECEIVES $4 MILLION—The state's trauma system has been awarded a $4 million federal demonstration contract to expand. Funds will be used to purchase a mobile radio for each of the 900 public and private ambulances used in the system and makes possible communication with hospital trauma centers, law enforcement and fire officials. The contract also includes money to train 5,000 emergency medical technicians to work in ambulances and emergency rooms, and for postgraduate training of critical care nurses and emergency room physicians. Also, Overland Critical-Care Vans will be staffed and equipped for transfering critical patients.

BI-STATE RMP AWARDED FUNDS—Regional Medical Program Service has received operational funds of $594,507 to accommodate a shift in the starting date of the Program's fiscal year from October 1 to January 1, thus extending the present fiscal year three months. Included in the operational funds is money for two health manpower education programs, one in the St. Louis metropolitan area, and the other covering 27 southeastern Illinois counties.

GONORRHEA GUIDELINES MODIFIED—Confronted by the increasing incidence of gonorrhea, coupled with more treatment failures due to inefficient treatment schedules, the government's Center for Disease Control (CDC) has redefined its recommendations for gonorrhea therapy. Addition of Trobicin (spectinomycin), a new antibiotic, and a new treatment schedule for uncomplicated gonorrhea have been announced.

Under previous recommendations, failure rates as high as 30 percent were reported for penicillin G. The treatment failures were partly attributed to the appearance of resistant gonorrhea strains in many areas, particularly Southeast Asia and coastal regions of the U.S.

They also were traced to the use of inadequate doses of penicillin G or the wrong type of penicillin by physicians. It is emphasized that long-acting forms of penicillin, such as benzathine penicillin G which is effective in treating syphilis, have no place in the treatment of gonorrhea. Procaine penicillin G administered parenterally remains the recommended treatment but the dosage was doubled for men to 4.8 million units—an amount previously used for women only. Even this increased dosage should be exceeded in order to approach a 100 percent cure rate.

In addition, one gram of oral probenecid should be administered at least 30 minutes before the penicillin G to delay penicillin excretion and achieve better concentrations against the gonococcus. The recommendations included, as an alternative to injectable penicillin G, a semisynthetic penicillin, ampicillin, in a 3.5-gram oral dose given simultaneously with 1 gram of probenecid. The new treatment schedule calls for the use of Trobicin as a parenteral alternate to penicillin for patients who are allergic to penicillin, ampicillin, or probenecid or who have suffered a previous hypersensitivity.

WEST SUBURBAN FAMILY PRACTICE CENTER RECEIVES GRANT—The U.S. Department of Health Education and Welfare, Public Health Service Division, has advised West Suburban Hospital, Oak Park, that a grant in the amount of $210,000 has been approved for the hospital's new Family Practice Center.

The center received approval of its program by the AMA's Family Practice Review Committee in 1970. It was the 30th such program to receive approval in the U.S., and the second in Illinois.

NEW PRESIDENT OF THE AMERICAN HOSPITAL ASSOCIATION—John Alexander ("Alex") McMahon, North Carolina, has been named president of the American Hospital Association (AHA). McMahon is presently president of North Carolina Blue Cross and Blue Shield.

DOCTORS FOR PEOPLE PROGRAM—Forty physicians on the staff of Mount Sinai Hospital Medical Center, Chicago, have set up private practice as part of a new, comprehensive care program to improve out-patient services. The innovative system of health care frees teaching and research staff doctors for personalized medical service.

Under the program, staff physicians in each of the hospital's clinical departments have formed private medical group practices. The physicians and dentists will occupy offices and examining rooms in the Professional Building, and serve patients from the immediate Lawndale community and the metropolitan area at large. (An estimated 12 doctors now practice in Lawndale, a community of more than 150,000.) Under the plan, clinic patients will be able to choose their own, private doctor.

NEW ISMS PUBLIC AFFAIRS ASSISTANT—Mr. Anthony "Tony" Calabrese, Jr., has joined the ISMS staff as Public Affairs Assistant. He is a graduate from Northeastern Illinois University with a major in political science and a speciality in Asian studies. He later received his Master of Arts degree from Northeastern in political science. Previously, Mr. Calabrese taught in the Chicago Public Schools.

PHYSICIANS IN THE NEWS—John M. Moran, M.D., has joined the Loyola University Stritch School of Medicine as an associate professor of cardiovascular and thoracic surgery, and will serve also as assistant chief of cardio-thoracic surgery at Hines V.A. Hospital.

R. L. Dewald, M.D., a well-known scoliosis specialist, has been named chairman of orthopedic surgery at the Loyola University Stritch School of Medicine.

Harvey White, M.D., head of the Department of Radiology at The Children's Memorial Hospital, will have dual leadership role when he becomes chairman of the Department of Radiology of Northwestern University Medical School, effective this September.

Mr. Louis Gdalman has been appointed as professor of medicine at Rush Medical College, Rush Presbyterian St. Luke's Medical Center, Chicago.

Harry A. Fozzard, M.D., Chicago; Ramon E. Casas, M.D., Evanston; and Ina J. Beinstein, M.D., Winnetka, have been granted fellowships in the American College of Cardiology.

New Fellows of American College of Physicians include:

Chicago: Arthur Atkinson, Jr., M.D.; Lloyd A. Ferguson, M.D.; Jessie Hano, M.D.; John S. Schweppe, M.D.; and Armando Susmano, M.D.
Evanston: Ramon E. Casas, M.D.
Freeport: C. William Metcalf, M.D.
LaGrange: Conrad Fischer, M.D.
Maywood: Marion Brooks, M.D.
Morton Grove: Sheldon Coehn, M.D.
Oak Forest: Dodda B. Rao, M.D.

New Members of American College of Physicians include:

Blue Island: Laszlo Koos, M.D.
Chicago: Richard L. Byyny, M.D.; Joseph L. Dadding, M.D.; Robert W. Hedger, M.D.; Stanley J. Heller, M.D.; and J. Kevin O'Donoghue, M.D.
McHenry: Edward F. Wilt, Jr., M.D.
Springfield: S. David Ross, M.D.; and Albert R. Siegel, M.D.

Leading Pediatrician Retires



Dr. Ralph H. Kunstadter, 66, a leading Chicago pediatrician, will retire in October after completing a 43-year career. He is associate professor of pediatrics at Northwestern University Medical Center. Dr. Kunstadter has served on several committees for the Illinois State Medical Society and for the State of Illinois. Dr. Kunstadter and his wife, Marjorie, will take up full-time residence at their second home in St. Croix, Virgin Islands.

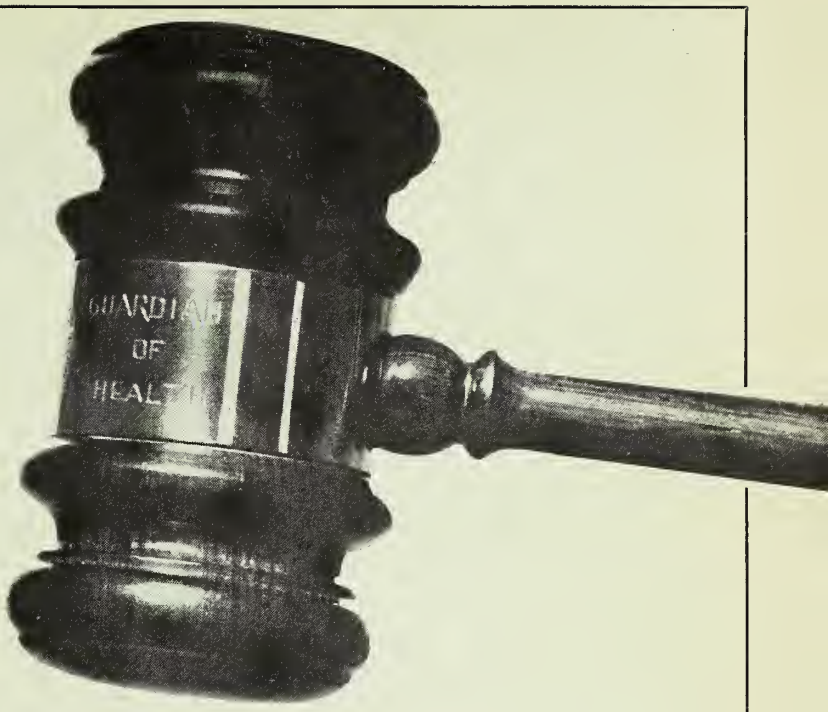
Dr. Jirka at Rock Island Hospital Dedication



Dr. Frank J. Jirka, Jr., (center), ISMS president, was among the distinguished guests at the recent dedication of Rock Island Franciscan Hospital. He is pictured with Dr. Robert Graham (left), president of Rock Island County Medical Society, and Don Wooten, Rock Island newsman who has won six ISMS Medical Journalism Awards.

BEG YOUR PARDON—In the August "Doctor's News" it was erroneously indicated that Dr. Charles McCartney is president of Chicago Medical Society. In fact, Dr. McCartney is president-elect. The president is Dr. Charles Weigel, River Forest.





Legislative Report . . .

At both the state and national levels, elected and governmental officials have been asserting a great deal of interest in the health care field.

Health care in general is a very important topic, but especially this year, as it is a national election year and everyone running for office seems to be getting into the act of health care and its delivery.

Major issues of health care ranging from abortion to nursing homes have been discussed and debated at the state level, where you and I are affected directly by the passage of such legislation. Almost 20 percent of all legislation introduced into both the House and Senate during the spring session of the General Assembly, Jan. 1, 1972, through June 30, 1972, affected medicine in one form or another.

The effectiveness of the state medical society can be attributed to the valuable help which many physicians gave during the year.

Illinois physicians throughout the state enhanced the position of the ISMS by providing expert testimony on various legislative bills that were heard in Springfield. Physicians gave additional help on medical issues by either phoning their respective legislators or writing a personal note expressing interest in a specific topic.

If you are not involved in the legislative process, but are concerned about the laws which are passed in Illinois, make yourself aware of the issues at hand and express your personal views to the legislators in your district.

The following analysis is presented to give you a general view of that legislation which was acted upon during the 77th General Assembly. If you should desire any further information with reference to this report, please contact the Governmental Affairs Division of the State Medical Society.

Alfred J. Faber, M.D.
Chairman, Government Affairs Council

Licensing & Registration Exclusively a State Function

On April 28 the Governor signed into law House Bill 3636—which declares that the licensing and registration of 30 different professions (Physicians, Dentists, Nurses, etc.) vocations and occupations is exclusively a state function and prohibits the licensing of these professions by home rule units.

The new Illinois Constitution declared that, "a home rule unit shall have only the power that the general assembly may provide by law," and one of these powers is "to license for revenue or impose taxes upon or measured by income or earnings or upon occupations."

Although the home rule unit was prohibited by the Constitution from licensing for revenue —unless that power was granted by the General Assembly—it may have only been a matter of semantics. A home rule unit may have decided that it should produce a directory of physicians for reference use. To do so, it would need the home and office address of each physician within that municipality.



Using this type of an end-run tactic, the home rule unit could have charged a fee for licensing just to cover the administrative cost of producing such a directory, as well as maintaining the administrative personnel cost. Any revenue not used by these personnel would have been returned to the general fund.

The Illinois State Medical Society joined various other professions in the state to coordinate all legislative efforts for the passage of this bill. Many Illinois physicians made contact with their respective legislators with reference to this bill and were the effective force needed to win this battle.

"Certificate of Need" Bill Defeated

"Certificate of Need" is the common term in legislative circles for determination of the qualifications of persons establishing a hospital or long-term care facility and the planning and development of these facilities.



This bill (HB 2653) and the concepts it envelopes is one of the most controversial and important issues confronting the doctors in Illinois. The ISMS House of Delegates has firmly established the policy that this type of health planning will only be supported when physicians are a significant part of the decision making process at the local level.

Doctors are not alone in their concern regarding the development of this issue. In August, 1972, the Chicago Home Rule Commission urged that the Chicago City Council (and not the state) should control where new hospitals and hospital extensions go.

This issue will certainly be debated in the 78th General Assembly (Jan. 1973). All physicians in Illinois should become fully aware of the ramifications of such legislation and actively follow the developments on this matter in 1973.

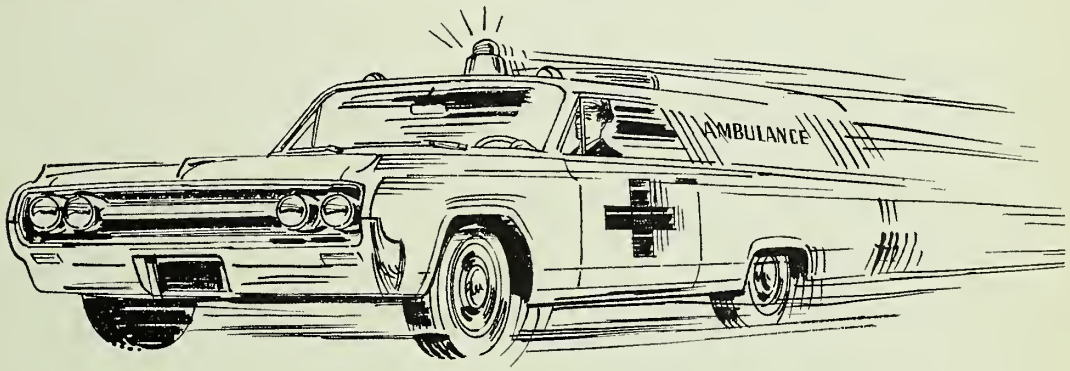
Illinois Health Facilities Authority Established

With passage this session of the Illinois Health Facilities Authority Act (HB 493), the legislature took a major step in providing financing for non-profit health entities (hospitals, etc.).

The seven member Authority Board, appointed by the Governor with the advice and consent of the Senate, will have the power to enter into contracts, issue bonds, charge rentals or fees for services or facilities furnished, and establish rules and regulations regarding the use of these services or facilities.

The Authority may make loans to participating institutions in order to refinance indebtedness, alleviate hardships on the institutions, or reduce rates. The Authority may lease projects to institutions and transfer the project to the institution open repayment of the indebtedness.

This law additionally requires that any plans involving the making of loans or the issuing of bonds be submitted to the Comprehensive Health Planning Agency for review and comment.



Legalize Paramedics

The Emergency Medical Treatment Act was amended to permit establishment of hospital pilot programs in which mobile intensive care personnel (paramedics), under the supervision of a physician, could provide emergency medical care at the scene of an accident, enroute to a hospital, and until care can be assumed by the regular hospital staff.

The Amendment (SB 1571) additionally exempts from civil liability the physician or nurse who in good faith gives emergency instructions to mobile intensive care personnel at the scene of an emergency. This law also exempts the "paramedic" who follows the instructions.

The Department of Public Health must approve these hospital based pilot programs. In 1973, the Department is mandated to report to the General Assembly on the effectiveness of the program.

The law also specifically delineates what the mobile intensive care personnel can do:

1. Render rescue, first-aid and resuscitation services.
2. Perform cardiopulmonary resuscitation and defibrillation in a pulseless, nonbreathing patient.
3. Where voice contact is maintained and a telemetered electro-cardiogram is monitored by a liscensed physician or a registered professional nurse (who has completed training course approved by the Department and is authorized by the physician), the personnel may do any of the following upon order of the physician or nurse:
 a. Administer intravenous saline or glucose solutions.
 b. Perform gastric suction by intubation.
 c. Administer parenteral injections of any of the following classes of drugs and their appropriate antidotes:
 i. Antiarrhythmic agents
 ii. Vagolytic agents
 iii. Chronotropic agents
 iv. Analgesic agents
 v. Alkalinizing agents
 vi. Vasopressor agents
4. During training administor parenteral medications under the direct supervision of a liscensed physician or registered professional nurse.

The Illinois State Medical Society is working with the Illinois Department of Public Health to promulgate the rules and regulations implementing the law.

New Action on Blood—Purchased or Donated

In 1971, the Illinois General Assembly enacted into law H.B. 16—which relieved blood donors, physicians, hospitals, and blood banks from liability in giving blood transfusions. This law was drafted pursuant to the Illinois Supreme Court decision on the Cunningham Vs. McNeal Memorial Hospital suit.

H.B. 16 has an expiration date of July 1, 1973. As of that date, those involved with blood whether it be donor, physician, hospital or blood bank will no longer receive legislative immunity.

House Bill 4445, pending the governor's signature, is aimed at creating a uniform voluntary blood donor system in the state. In accomplishing this, any individual, blood bank, hospital, firm, corporation or any other entity must comply with the criteria for donor selection to be promulgated by the Illinois Department of Public Health.

In addition, any person who withdraws blood from an individual or separates blood into components shall afix to each container of such blood or components a label in a form specified by the IDPH which includes an indication of whether the blood was obtained by purchase or donation.

When blood is administered by transfusion in this state, the identification number of the unit



of blood will be recorded in the patient's medical record, and the label on the container may not be removed before or during the administration of the blood.

After July 1, 1973, no blood initially acquired by purchase may be administered by transfusion in Illinois unless the physician in charge of the treatment of the patient has directed that such purchased blood be administered to that patient and has specified in his medical record the reasons for such action.

Mandatory School Eye-Screening by Optometrists and Ophthalmologists Defeated

After a one year battle in the Illinois General Assembly, House Bill 2033 remains on 3rd reading in The Senate.

House Bill 2033—would have required that eye screening examinations for school children entering kindergarten, first, fifth and ninth grades must be performed by a licensed ophthalmologist or licensed optometrist and reported on separate forms.

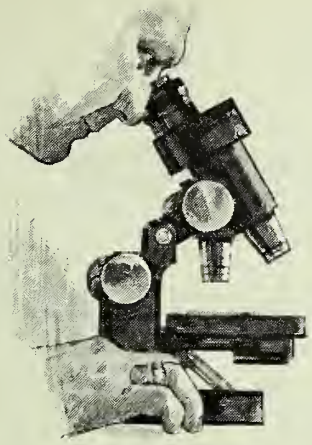
This legislation would have prohibited school nurses, pediatricians, general practicioners, internists and eye screening technicians from giving the eye screening tests at the local school district level, as mandated by the passage of House Bill 2113 during 1971.

As a pre-emptive piece of legislation, this bill would have abolished the present vision screening program as part of the regular school physical examination.

This would have entailed an additional cost to parents of more than 7 million dollars a year and added to the Public Aid Department's budget by more than 1 million dollars annually.

Each year more and more children are entering school for their first time or at least in their respective grade levels. Taking this total figure into account and dividing it by the total number of optometrists and ophthamologists in the state, would mean an increase in the number of patients to be seen (for just eye screening exams) by an additional 270 new patients per year.

There now exists in Illinois a shortage of ophthamologists and optometrists, especially in the downstate areas. This proposal would have only aggravated the present situation.



State Hospitals and Permit Physicians

Inspired by general public reactions to the medical care being given to patients in state operated hospitals, the General Assembly took swift action and passed Senate Bill 1530.

This act, which now awaits the signature of the governor, had traveled a rocky road from its inception on April 26, 1972, through June 6 of this year. At one time the bill was tabled but then was brought back to the House floor for further consideration and subsequently was passed.

Under this bill the Medical Practice Act will be amended to provide that state hospital permits of physicians not otherwise licensed to practice may be renewed only twice after July 1, 1973, for one year periods each, with all original permits and renewals to expire on the July 1 after issuance. After July 1, 1974, all permit holders seeking renewal will be required to pass a new examination to be given by the Department of Registration and Education, or an equivalent examination.

German Measles and Marriage

House Bill 1324, which has been signed by the Governor, amends an Act in relation to marriages to require a *physician's affidavit* that the woman has been tested for immunity to rubella (German Measles) before a marriage license may be issued.

The Illinois Department of Public Health shall establish and promulgate tests and immunization procedures and the necessary reporting forms.

Exemption for AMA/ERF Loans

The Illinois General Assembly has again extended the expiration date for medical student loans under the American Medical Association/ Educational Research Foundation (AMA/ERF) program.

The Legislature amended the Illinois Usury Law on July 1, 1970, to exempt loans under the AMA/ERF program from the Usury Law limitation (8 percent) in Illinois until December 31, 1972.

Since 1962, 1,676 loans totaling $1,754,544 have been made to students attending medical schools in Illinois under this program. The loans are in effect unsecured installment loans which would under ordinary circumstances not be available to the borrower and would carry "add on" interest rates of 6 percent or more, which equals 11 percent or more in simple interest.

House Bill 4427, signed by the Governor on August 8, 1972, extends this exemption to medical student loans until Jan. 1, 1978.

The passage of this bill will assist many financially needy students in attending their goal of practicing medicine, and thus will help alleviate the physician shortage.

State Mental Institutions to Meet Minimum Requirements

An act (House Bill 3602) which has passed both houses of the General Assembly, calls upon the Illinois Department of Mental Health to report before Feb. 15 (a change in date from the prior reporting date of Dec. 15) of each year to both the Governor and the General Assembly.

The Department will make its annual report based on a list of all state institutions indicating those which meet the minimum requirements imposed by state laws and regulations on private facilities providing comparable services and those which do not meet such standards.

The report also indicates those that do not meet the minimum standards, the areas of deficiency and recommendations for compliance.

Institutions or parts thereof which have not been fully accredited by the federal government shall also be reported together with the reasons for nonaccreditation.

ISMS

Leadership Conference

Regency Hyatt House, O'Hare Airport, Chicago

SUNDAY, OCTOBER 29, 1972

Malpractice Problems in Illinois

r
b
i
t
r
a
t
i
o
n as a means of dispute settlement

Topics to be discussed will include:

. . . status of malpractice in Illinois

. . . explanation of rising malpractice insurance rates

. . . the role of arbitration in malpractice disputes

. . . the California arbitration Plan

. . . use of arbitration by hospitals and clinics

I will attend the ISMS Leadership Conference, October 29, 1972, at the Regency Hyatt House, Chicago

Enclosed is my check for $.....covering lunch(es) ($10.00 per person)

NAME

ADDRESS

CITY ZIP.....

Mail to: ILLINOIS STATE MEDICAL SOCIETY, 360 N. MICHIGAN AVE., CHICAGO, IL. 60601

Obituaries

***Bradel, John M.,** Champaign, died July 5, at the age of 62. Dr. Bradel retired from the medical profession in 1971. He left Aurora to accept a position as staff physician at McKinley Hospital for the University of Illinois.

***Ekstrand, Rowland M.,** Waukegan, died June 30, at the age of 67. He was past president of the Lake County Medical Society. From 1934 to 1937, he was the city physician for Waukegan. He was also associated with the Besley Clinic in Waukegan for 20 years.

***Firth, J. O.,** Chicago, died July 5, at the age of 74. He graduated from the University of Illinois Medical School. He served for many years as secretary of the Monmouth Physicians Club.

Flexer, H. N., Joliet, died at the age of 83. He practiced medicine in Joliet for 35 years. He was an eye, ear, nose and throat specialist on the surgical staff of the Rock Island Lines in Joliet area.

***Gritti, Emil John,** Mattoon, died July 9, at the age of 44. He had been a urologist at the Link Clinic in Mattoon since 1969. Dr. Gritte was also a faculty member at the University of Illinois Basic Medical Sciences. He was president of the Area Medical Planning Council.

Huber, Paul R., Wilmette, died July 11, at the age of 81. He was a retired physician and surgeon.

***Kallal, Thomas E.,** Cicero, died July 8, at the age of 64. He was a graduate of the Loyola School of Medicine and a staff member of St. Anthony of Padua Hospital. He retired one and a half years ago from private practice after 40 years work in Chicago. Dr. Kallal also served as Cicero Health Commissioner.

***Keehen, John H.,** Ft. Lauderdale, Fla., died July 11, at the age of 65. He was on the staff of the Little Company of Mary Hospital in Evergreen Park and maintained a private practice until his retirement in 1965.

****Klein, Samuel,** Aurora, died June 30, at the age of 89. He was a graduate of Loyola Medical School and was a physician, in Aurora, for 50 years.

***Leschuck, Alexander,** Twin Lakes, died June 24, at the age of 57. He was a medical advisor to McHenry County Board. He was also senior surgeon in U.S. Public Health Services, Department of Health, Education and Welfare.

(Continued on page 254)

Skin Saver



Alpha-Keri®

therapeutic bath oil

locks in moisture

relieves dry, itchy skin with the first bath or shower.

See PDR. Supplied: 8 and 16 fl. oz. bottles; 5 oz. aerosols.

WESTWOOD PHARMACEUTICALS INC. Buffalo, New York 14213

Send samples of Alpha-Keri bath oil.

DR. _____

ADDRESS _____

CITY STATE ZIP 7

New pharmaceutical specialties

(Continued from page 234)

POLYCILLIN INTRA-MUSCULAR: Penicillin & Derivs. ℞
Manufacturer: Bristol
Nonproprietary Name: Ampicillin Trihydrate
Indications: Infections due to susceptible organisms.
Caution: Hypersensitivity to Penicillin
Precautions: Those usual with antibiotics
Dosage: Adults—250 mg. i.m. q.i.d. in equally spaced doses.
Children—50 mg./kg/day. of body weight in equally divided doses.
Supplied: Vials 2.5 gm.

SUMYCIN '250' HYDRO-CHLORIDE:
SUMYCIN '500' HYDRO-CHLORIDE: Antibiotic-B & M Spectrum ℞
Manufacturer: Squibb
Nonproprietary Name: Tetracycline Hydrochloride
Indications: Infections due to susceptible organisms.
Caution: Hypersensitivity to Tetracycline.
Precaution: Those usual with antibiotics.
Dosage: Adults—1-2 gm. daily, depending upon type of infection.
Children—10-20 lb./gm. body weight divided in 4 equal doses.
Supplied: Tablets 250 and 500 mg.

$31 Million in Drug Abuse Treatment and Rehabilitation Grants Announced

The U.S. Department of Health, Education and Welfare announced August 17, 1972, in a public news release that the White House Special Action Office for Drug Abuse Prevention and the National Institute of Mental Health had been funded 54 new grants totalling $31,327,055 to provide treatment and rehabilitation services for narcotic addicts and other drug abusers.

Among the 54 new grants are also nine "Initiation and Development" grants, which are awarded to individual communities to develop reliable estimates of the extent of the local drug problem and assess the need for treatment and rehabilitation programs.

★
Specialized Service
IN
PROFESSIONAL LIABILITY INSURANCE
is a high mark of distinction
THE
MEDICAL PROTECTIVE COMPANY
FORT WAYNE, INDIANA
Professional Protection Exclusively since 1899

CHICAGO AREA OFFICE: T. J. Pandak, J. C. Kunches, and L. R. Gannan, Representatives
T. J. Haehn, Consultant
815 Commerce Drive, Suite 102, Oak Brook, Illinois 60521 (312) 325-7314
SPRINGFIELD OFFICE: W. J. Nattermann, Representative
426½ South Fifth Street, Springfield 62701 (217) 544-2251

What Goes On

(Continued from page 224)

October 14-20—The Abraham Lincoln School of Medicine, University of Illinois

The Annual Otolaryngologic Assembly of 1972

The University of Illinois offers a condensed basic and clinical program for practicing otolaryngologists under the direction of Emanuel M. Skolnik, M.D. It is designed to bring to specialists current information in medical and surgical otolaryngology.
Contact: Otolaryngology, P.O. Box 6998, Chicago, IL 60680

Ear and Eye Infirmary of the University of Illinois Hospital

October 14-19—American Academy of Pediatrics

41st Annual Meeting

Scientific papers to be presented during the general sessions include: Immunizations progress and problems, school problems, what the pediatrician should know about atherosclerosis and its prevention, the drop-out and the exciting new development in pediatrics.
Several pertinent scientific presentations will also be featured during the specialty section meetings at the annual meeting.
Contact: American Academy of Pediatrics, Department of Public Information, 1801 Hinman Avenue, Evanston, IL 60204

October 20-22—Rockford School of Medicine, Abraham Lincoln School of Medicine, and Cook County Hospital.

Seminar on "Practical Applications of Some of the Difficult Problems of Family Practice.

Registration: Advanced registration is necessary, and can be made through the above Departments of Family Practice or through your Pfizer Representative

Pheasant Run Inn, Chicago

October 24-26—AMA Conference on Continuing Medical Education

Third National Conference of State Medical Association Representatives on Continuing Medical Education.

The general objectives of the Conference will be:

1) To provide assistance to the component societies of the AMA in the field of continuing medical education;

2) To focus attention of the state medical associations on continuing medical education;

3) To provide a forum for the exchange of ideas among the associations; and

4) To encourage state associations to become involved in continuing medical education, each in its own way, after over-all study of the problem.

The first two Conferences, held in 1968 and 1970, were considered highly successful by those who attended.
Contact: American Medical Association, 535 N. Dearborn Street, Chicago, IL

Ambassador Hotels, Chicago, IL

October 25—The Barren Foundation

Seventeenth Seminar for Physicians: "The Hairy Female"

All interested physicians and other professional persons are cordially invited to attend. There is no charge.
Contact: Barren Foundation, 6 East Monroe, Chicago 60603

Lower Level of the Auditorium, Room 0708, Medical School Building

October 25-27—University of Texas

Diseases of Vulva and Vagina

This course will provide an intensive review of the basic pathology and management of a selected group of diseases of the vulva and vagina, in-depth discussions of important diseases such as Leukeoplakia, Herpes genitalis, and viruses in cancer.
Registration Fee: $85.00
Contact: The office of the dean, The University of Texas, Graduate School of Biomedical Sciences at Houston, Division of Continuing Education, P.O. Box 20367 Houston, TX 77025

October 29—Illinois State Medical Society

ISMS Leadership Conference

Program begins at 9:25. Topic: Use of Arbitration in Malpractice.
Contact: Illinois State Medical Society, 360 N. Michigan Avenue, Chicago 60601

O'Hare Regency Hyatt House Chicago

November 3—Illinois State Medical Society, Illinois Nutrition Committee, Illinois Heart Association and Illinois Department of Public Health

15th Conference on Nutrition and Medicine

Contact: Illinois State Medical Society, 360 N. Michigan, Chicago 60601

Southern Illinois University, Carbondale

November 9-10—Borgess Hospital

Third Annual Cardiology Symposium

The theme of the symposium will be "Cardiology For the Practitioner."
Contact: Dr. Robert Barcala, Director of Cardiology, Borgess Hospital Kalamazoo, MI 49001

Borgess Hospital, MI

(Continued on page 254)

View Box

(Continued from page 204)

DIAGNOSIS: *Thalassemia*—Thalassemia major is the homozygous form of this disease. It usually occurs in Mediterranean people. The blood picture is a severe microcytic, hypochromic anemia with elevated counts for reticulocytes, target cells and stippled cells. Radiologically the changes result from erythroid hyperplasia of the marrow. All bones can be involved initially. If the patient survives to later life there may be some regression of bone changes.

Characteristically the cortices are thinned with absorption of the trabecules resulting in a coarsened trabecular pattern. There is underconstriction of bone giving a square appearance of short, tubular bones and an "Erlenmeyer-flask" deformity of the long bones. In the skull, the diploic space widens, with external displacement and thinning of the outer table. There is characteristically no involvement of the occipital bone because of the lack of hematologic tissue of this site. The facial bones are involved with marrow hyperplasia causing failure of pneumatization of the sinuses. The ribs show a coarsened trabecular pattern, cortical thinning and widening. The spine shows an increase in the size of the vertebral body as a result of the marrow hyperplasia in contradistinction to the bioconcavity seen in sickle cell disease. In thalassemia there is no evidence of thrombosis and infarction which is the hallmark of sickle cell disease.

What Goes On

(Continued from page 253)

November 26-29—American Academy of Orthopaedic Surgeons

Emergency Care and Transportation of the Sick and Injured

Purpose of courses: To teach the important fundamentals necessary for accurate preliminary evaluation of the sick and injured; To teach techniques of Emergency Care to save life and prevent additional injury or Complications and To develop judgment in determining the method and time of transportation to established medical facilities.
Content will be based on the AAOS Text "Emergency Care and Transportation of the Sick and Injured."
Tuition Fee: $50.00
Contact: Marshall B. Conrad, M.D., 4960 Audubon Avenue, St. Louis, MO 63110

Chase-Park Plaza Hotel, 212 North Kingshighway, St. Louis, MO

ekg of the month

(Continued from page 215)

Answers:

1C, 2A,B,C. The EKG shows a large current of injury or ST segment elevation. P waves are clearly seen in the limb leads (I, II, and III), so this is sinus rhythm. From a vectorial viewpoint, the ST segment is directed leftward, inferiorly, and posteriorly making it positive in leads I, II, III, av F, and V_6 and negative in leads V_1 and V_4. This would place the myocardial infarction in the inferior-apical portion of the left ventricle and would speak for a large area of damage. All of the answers in the second question are correct because the patient is in the early stages of cardiogenic shock.

Obituaries

(Continued from page 251)

****McDermott, Raymond A.,** Chicago, died February 15, a the age of 77. He was a physician for more than 50 years.

****Miller, Edwin Morton,** Chicago, died at the age of 83. He served on the faculty of the University of Illinois College of Medicine. For many years he was affiliated with the Cook County and Children's Memorial hospitals and the Presbyterian-St. Luke's hospital.

***O'Malley, Bernard,** Boone County, died July 11, at the age of 55. He graduated from Loyola University, School of Medicine, Chicago, in 1945.

***Traut, Eugene F.,** Oak Park, died July 15, at the age of 78. He was on the staff at County Hospital for more than 50 years and was director of the hospital's arthritis clinic. He had published numerous medical articles in English and German. He authored a book titled *Rheumatic Diseases.*

***Waldman, Leonard F.,** Chicago, died July 3, at the age of 69. He had been a physician for the last 43 years with offices in Chicago. Also, he was a member of the staff at Bethany Methodist and Resurrection Hospitals.

***Zablocki, George H.,** Glenview, died July 20.

**Denotes member of ISMS*
***Denotes member of 50-Year Club and ISMS*

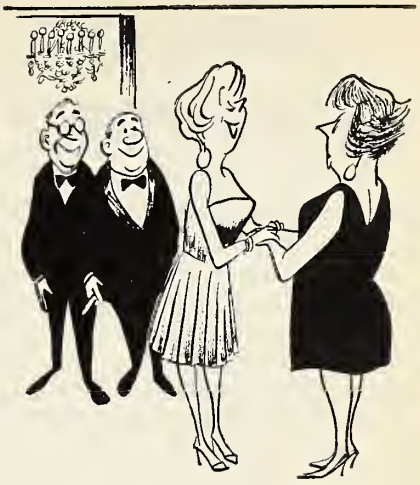
15th Annual Conference on Nutrition and Medicine

November 3, 1972
10:00 am
Carbondale

Southern Illinois University

Co-Sponsored By:
ISMS
Illinois Nutrition Committee
Illinois Heart Association
Illinois Department of Public Health

For Further Information Contact:
Illinois State Medical Society
360 N. Michigan Ave.
Chicago, IL 60601



"Your dinner was perfect—from soup to 'Dicarbosil'."

Dicarbosil®
ANTACID

Write for Clinical Samples
ARCH LABORATORIES
319 South Fourth Street, St. Louis, Missouri 63102

COOK COUNTY

Graduate School of Medicine

CONTINUING EDUCATION COURSES
STARTING DATES—1972

SPECIALTY REVIEW COURSE IN SURGERY, Part I, October 23
SPECIALTY REVIEW COURSE IN OB-GYN, October 16
STATE & NATIONAL BOARD REVIEW COURSE, Basic, Nov. 5
STATE & NATIONAL BOARD REVIEW COURSE, Clinical, Nov. 13
BLOOD VESSEL SURGERY, One Week, October 9
PRE & POSTOPERATIVE CARE OF PATIENTS, 4 Days, Nov. 8
SURGERY OF TRAUMA, 4 Days, December 11
SYMPOSIUM ON SHOCK, 2 Days, December 15
MANAGEMENT OF COMMON FRACTURES, One Week, Oct. 23
ADVANCES IN OBSTETRICS & GYNECOLOGY, One Week, Nov. 13
BASIC OBSTETRICS, One Week, November 27
BASIC GYNECOLOGY, One Week, December 4
BASIC INTERNAL MEDICINE, One Week, October 2
BASIC ELECTROCARDIOGRAPHY, One Week, October 9
INTERMEDIATE CARDIOLOGY, 4½ Days, October 16
FAMILY PRACTICE REVIEW, One Week, October 30
BASIC DERMATOLOGY, One Week, October 9
CLINICAL PSYCHIATRY, Four Days, October 31
CLINICAL ANESTHESIA PRACTICE, One Month, October 2

Information concerning numerous other continuation courses available upon request.

Address:

REGISTRAR, 707 South Wood Street,
Chicago, Illinois 60612

ASSOCIATE MEDICAL DIRECTOR

Inland Steel Co., Indiana Harbor Works, one of Chicagoland's largest manufacturing complexes is seeking an Associate Medical Director.

Our Medical Department is a fully staffed complex including an X-Ray, Laboratory, and an occupational hygiene division.

There is a full range of medical activities including traumatic, pre-placement and consultative services in a plant whose population exceeds 20,000. Salary is negotiable with an outstanding no-cost benefit package included.

Reply to:

Mr. C. M. MITCHELL
Assistant Director, Personnel

INLAND STEEL CO.
3210 Watling Street East Chicago, Ind. 46312
Equal opportunity employer

OCCUPATIONAL PHYSICIAN

Plant Medical Director and staff positions open in our Medical Department at Cleveland, Ohio and Central Illinois plants.

Good salary potential with continuing growth opportunity — excellent fringe benefits.

Send confidential resume to: G. W. Grawey, M.D., Medical Director, Caterpillar Tractor Co., Peoria, Ill. 61602

An Equal Opportunity Employer

CATERPILLAR

Caterpillar, Cat and ⊞ are Trademarks of Caterpillar Tractor Co.

"Hot Line" Crisis Counseling

(Continued from page 221)

provided from any foundation grant or religious or philanthropic organization. Office space was donated without charge and expenses consisted mainly in the cost of telephone, mailing and direct material or financial assistance to clients. Current budget is approximately $3,600 a year but this will probably increase since one obvious and currently unfulfilled need is for short-term housing for crisis situations.

Summary

1) A "hot-line" type of emergency telephone counseling service for pregnant women has operated in metropolitan Chicago for six months.
2) The volume of calls would indicate that this service responds to a previously unmet need in the community.
3) A total of 1,739 personal contacts were made by telephone; 494 women required continuing or long-term contact.
4) 72 women required a direct medical referral to either a private physician (67%) or a clinic (33%).
5) Funding was achieved entirely through private donations and fund-raising events conducted by volunteers. ◄

References

1. Kaplan, D., "Observations on Crisis Theory and Practice," *J. Soc. Casework,* 49:151, 1968.
2. Hirst, J., and Strouse, F. "The Origin of Emotional Factors in Normal Pregnant Women," *Am. J. Med. Sciences,* 196:1, 1938.
3. Kasanin, J., and Handschin, S.: "Psychodynamic Factors in Illegitimacy," *Am. J. Orthopsych,* 11:66, 1941.
4. Harrington, J. "Crisis Intervention Counseling for Women who are Pregnant," *Marriage and Family Newsletter,* 2:2, 1971.
5. Fishback, D. "Mental Illness Associated with Childbearing," *Elgin Papers,* 3:156, 1958.
6. Gardner, S. Psychosomatic aspects of Obstetrics in Williams Obstetrics 13th Edition, Appleton Century Crofts, New York, 1966.
7. Summerhill, L. Personal Communication:
8. Directory of Birthright Services, available from National Right to Life Committee, P.O. Box 9365, Washington, D.C. 20005.
9. Trout, L. "Services to Unmarried Mothers," *Child Welfare,* 35:21, 1956.
10. Panter, E. "Ego-Building Procedures that Foster Social Functioning," *J. Soc. Casework,* 47:139, 1966.
11. Reider, N. "The Unmarried Father," *Am. J. Orthopsych,* 18:230, 1948.
12. Boyd, D. "Mental Disorders Associated with Childbearing," *Am. J. Ob. Gynec.,* 48:148, 1942.

The authors: Eugene F. Diamond, M.D. is professor of pediatrics, Loyola University, Stritch School of Medicine, from which he received his M.D. In addition, Dr. Diamond has served in many capacities for ISMS in working with the Nutrition Committee. Rosemary Diamond is President, Birthright of Chicago. She received her A.B. from Mundelein College and is a social worker.

Many Definitions of Medical Education

The establishment of clearly defined goals seems little enough to ask. But too often it happens that the goals are formulated so diffusely as to be hardly more than words. Note, for example, a recent list defining medical education: (1) greater production of physicians, (2) more rapid production of M.D. graduates, (3) economy in production of M.D. graduates, (4) redefinition of the M.D. degree, (5) increased institutional opportunities to engage in physician training, (6) accomplishment of social objectives through the physician training program, (7) restructuring of the delivery system of medical care through reorientation of physician training, (8) increase of the patient service output of the physician training apparatus, and (9) pursuit of the course of greatest funding. (Irvine H. Page.: "Obfuscation by planning," **Modern Medicine—Editorials,** [Feb. 21] 1972, pgs. 89-92.)



Greatest Advance Since the Typewriter was Invented! No More Smeary Erasing— Covers Mistakes Instantly, Permanently!

SELF-CORRECTING TYPEWRITER RIBBON!

Most exciting, needed advance since the typewriter was invented! As of this moment, every messy, smudgy, smeary typewriter eraser in the world hits the scrap heap for good. No more erasing—ever! Bottom half of miracle ribbon is like a magic wand that makes errors disappear before your eyes. To make corrections, just back space, shift ribbon selector and retype error. Presto! White ink makes error completely invisible. Order extra ribbons for friends. This is one gift they'll love you for! No CODs.

MAIL ORDER MART, Dept. 14
2701 Sterlington Road, Suite 132
Monroe, Louisiana 71201

Please send me the quantity of ribbons checked below. If not satisfied, I will return ribbons within 10 days for full refund.

☐ 1 ribbon $3.50 ☐ 2 ribbons $6.00

Brand Name of Typewriter—
☐ Standard ☐ Electric ☐ Portable

Name_____

Address_____

City_____ State_____ Zip_____

CLASSIFIED ADVERTISING

Positions & Practice Opportunities

OB-GYN, GP, INTERNIST, QUINCY, ILLINOIS—2 modern hospitals with newest equipment, our office within two blocks. Above average earnings. Earnings guaranteed. Ranges to six figures. Positions avoilable now. Educationolly and culturally rated with best in state. Many recreational facilities. For details call collect 217-223-0505. Irving Brenner, Administrator.

PHYSICIAN WANTED—For general practice, or generol practice and orthopedic surgery. Attractive, prosperous, residential community of Geneseo with over 6,000, serving trade area of 29,000 population. Located on Interstate 80, 2½ hours from Chicago and 25 miles east of Quad-Cities metropoliton area of over 300,000 provides safe, ideal, small city living for family with excellent recreational facilities. New ultro modern $2,500,000 hospital with 110-beds. Office space and housing immediately available. Contact: Clement G. McNamara, 210 Elk Street, Geneseo, Illinois or phone collect: (309) 944-6431.

WANTED GENERAL PRACTITIONER, specializing in industrial medicine. Permanent position in modern northwest Clinic. Forty hour week, good salary, fringe benefits. Illinois Licensure a necessity. 'Phone Miss Schofield—(312) BE 7-8000.

TAKE ANOTHER LOOK AT COOK COUNTY HOSPITAL, SOMETHING REMARKABLE IS HAPPENING THERE. Our Psychiatric Department specializes in "Psychiatry for the People" and Board Certified or Board qualified psychiatrists are needed to enable us to help PEOPLE—all kinds of people. Attractive salories range from $30,-000.00 to $33,000.00 plus many meoningful fringe benefits including 25 days paid vacation and eleven paid holidoys. Send your application to Kermit T. Mehlinger, M.D., Acting Director, Department of Psychiatry, Cook County Hospital, 1835 West Horrison Street, Chicago, Illinois 60612.

PHYSICIAN FOR ACUTE ILLNESS DEPARTMENT and Emergency Room. Become a part of an expanding, dynamic multispecialty clinic in Midwest university community. Excellent solary, benefits. Write or call Medical Director, Carle Clinic, Urbana, Illinois 61801. Phone (217) 337-3239.

PRISON PHYSICIAN—17 to fill immediate vacancies. Salary range $26,370 to $32,280 annually. All Michigan civil service benefits. Must possess a license to practice medicine or osteopathic medicine and surgery in Michigan, plus five yeors of such experience. Send resume' to Mr. Richard D. Crable, Chief, Recruitment and Placement, Michigan Department of Civil Service, Lansing, Michigan 48913. (IMJ) An equal opportunity employer.

UNIVERSITY HEALTH SERVICE POSITIONS OPEN: General Proctitioner or Internist, full-time, for Medical Clinic. General Practitioner, full-time or Gynecologist for office gynecology and family planning services. (Gynecologist may elect to practice part-time in Chicago or Rockford.) Psychiatrist, full-time, for patient therapy and to head Mental Health Unit. Modern focility, good fringe benefits. Illinois license required; salary per qualifications. L. W. Akers, M.D., Director, UHS, Northern Illinois University, DeKalb, Illinois 60115.

UNUSUAL OPPORTUNITY FOR PHYSICIANS interested in the growing subspecialty of Emergency Medicine who prefer not to maintain an office. Join a rapidly growing fee-for-service group in the Emergency Departments of Chicogoland hospitals. Prefer surgeons, general proctitioners with experience in traumatic medicine, and coreer Emergency Physicians. Group is expanding, developing teaching programs. Excellent facilities, automated billing and collecting service, opportunity for research in emergency procedures. Address reply to: Medical Emergency Service Associated (MESA), S.C. 111 North Addison, Elmhurst, Illinois 60126. (312) 832-4504.

IMMEDIATE OPENING for OB-GYN, Internal Medicine, and Orthopedic specialties to establish successful practice with 14-man multispecialty group. Excellent group benefits; pension plan; modern clinic facilities; progressive community with excellent educational system including two colleges; city population 35,000; good recreational facilities; each specialty must be board eligible or certified; young man with military obligation completed. Contact: Business Manager, The Manitowoc Clinic, 601 Reed Avenue, Manitowoc, Wisconsin 54220.

WANTED: OB-GYN, SURGEON and INTERNIST for nine man group. Thirty miles southwest of Chicago, excellent hospital, housing and schools. $30,000 guarantee first year. Write to Box Number 782, c/o Illinois Medical Journal, 360 N. Michigan Ave., Chicago, Illinois 60601.

IMMEDIATE OPENING: INTERNIST or GENERAL PRACTITIONER to join six man multi-specialty group in northeastern Wisconsin. Excellent professional opportunity to practice in a friendly community, only two actively practiticing physicians (General Practitioners) in the community outside of our Clinic. Salary commensurate with training and experience first year and then full partnership. Ideal, safe small city living for the family on scenic Lake Michigan with excellent fishing, boating and hunting. All this and still only 1½ hours drive to Milwaukee or 45 minutes to Green Bay or lovely Door County. For complete details contact Robert E. Myers, M.D., Garfield at 23rd. Two Rivers, Wisconsin 54241.

3 EMERGENCY ROOM PHYSICIANS wanted to staff new E.R. facilities of 200 Bed Hospitol. 50 man multispecialty Clinic physically adjacent provides immediate consultation and support. No. pediatric responsibility. Michigan Resort City on Lake Michigan. Salary negotioble. Many fringe benefits. Reply to: John Rasmussen, Administrator, Burns Clinic Medical Center, P. C. Petoskey, Michigan 49770.

PHYSICIANS NEEDED: Orthopedic and General Surgeons, Urologists, Internists, OB—Gynecologists, and General Practitioners to establish independent practice in Petoskey, Michigan. The Midwest's Skiing Mecca and world famous summer resort community. Local college, excellent schools, seasonal sport, summer and winter concerts. A great selection of restaurants, theatre, hunting, fishing, golfing, sailing, unique and unusual shops and frequent airline service make this an unrivaled living area. New acute care general hospital will provide one year's rental on adjacent luxurious office suites, moving stipend, and negotiate other financial arrangements. Contact: Milton D. Rasmussen, Administrator or Wendell C. Trent, Asst. Administrator. Area Code 616-347-3985.

ASSOCIATE WANTED: GENERAL PRACTITIONER for extremely busy solo practice. 1970 gross income well over six figures. Ideal location in small Illinois community. New 100-bed hospital. 45 minutes from downtown St. Louis and 15 minutes from 26,000 acre Lake Carlyle. Excellent schools, churches, and recreation facilities. Salary arrangement or guaranty first year, leading to eventual buy-in. Write to Box Number 800, c/o Illinois Medical Journal, 360 N. Michigan Ave., Chicago, Illinois 60601.

GENERAL PRACTITIONER or INTERNIST for expanding group practice plan. Regular hours. Salary negotiable. Tax shelter plan. Illinois licensure required. Progressive city of 90,000 with cultural and recreational advantages. Write to Box Number 801, c/o Illinois Medical Journal, 360 N. Michigan Ave., Chicago, Illinois 60601.

PHYSICIAN to direct University Health Program. 18,000 students. Interesting work in an excellent community. Modern health facility. Salary competitive and negotiable. Fringe benefits. For further information send vitae to: Leo H. Frigo, M.D., University Health Service, Illinois State University, Normal, Illinois 61761 or call (309) 438-8655.

GENERAL PRACTITIONER—Excellent location in the Lost Pines of Texas area, growing community of 3,500 along the beautiful Colorado River. Has an excellent opportunity for a good family General Practitioner. Excellent small Hospital (25 beds) and Nursing Home (65 beds) complex, guoranteed salary if desired, clinic, ancillary services and other fringe benefits will make this difficult to turn down if interested in working in a progressive rural community only 40 miles from a metropolitan area. Smithville Hospital Authority; Irvin Row, Administrator, Box 89, Smithville, Texas 78957. Phone: AC 512-237-2441.

PSYCHIATRIC RESIDENCIES—Excellent, approved psychiatric education; intellectually demanding and clinically diversified in a stimulating, well-balanced program. Affiliated with Michigan State University's College of Human Medicine. The setting is in a culturally rich community; the serene, scenic Grand Traverse Bay area. Three year plan: $12,820 to $14,574; Five year plan: $14,637 to $27,436. Contact Dr. Paul E. Kauffman, Director of Psychiatric Training, Room 164, Traverse City State Hospital, Traverse City, Michigan 49684. An equal opportunity employer.

BLUE SHIELD REPORT FOR Illinois Physicians

ALTERNATIVE HEALTH CARE DELIVERY SYSTEMS

The following policy statement on alternative systems of health care delivery was adopted by the Board of Trustees of the Blue Shield Plan of Illinois Medical Service and first published in the July '71 issue of the Blue Shield Report.

"Over the years, the role of Blue Cross and Blue Shield as nonprofit community service organizations, has been to provide the public with a prepayment mechanism through which it might obtain the highest quality health care. Blue Cross and Blue Shield make available a variety of benefit programs from which consumers can choose the type of coverage which best meets their needs.

"Following experimentation and evaluation, innovations in health care prepayment traditionally have become part of Blue Cross and Blue Shield programs. This desire to innovate has been and will continue to be the foundation and strength of the voluntary health care system.

"While strengthening their existing programs, Blue Cross and Blue Shield desire to maintain their traditional leadership roles through continued experimentation with evolving forms of health care delivery and financing systems. Implicit in any offering of alternative systems in the delivery of health care is the free exercise of consumer options and physician control of their professional activities.

"Major current developments which offer promise for either effectiveness or economy of health care delivery include medical society foundations for medical care, health maintenance organizations, health care corporations, prepaid group practice, surgical care centers, model cities projects, and neighborhood health centers.

"Blue Cross and Blue Shield fully intend to continue to make available to the public their usual benefits with delivery and financing following traditional patterns. However, in addition to encouraging wider participation in their present programs, Blue Cross and Blue Shield plan to assist providers of services in the development of alternative approaches to health care delivery and financing. They also plan to implement these efforts by offering the public, as an option to existing Blue Cross and Blue Shield benefit programs, the opportunity of electing to receive benefits through alternative systems which meet the Blue Cross and Blue Shield standards. Blue Cross and Blue Shield feel that by making these choices available, they can better serve the community.

"Blue Cross and Blue Shield welcome expressions of interest from physicians and their medical societies, from other providers, employers, unions and other parties who desire to participate in these approaches to quality health coverage."

Booklet and Film on Drug Abuse for "Small Fry" Produced by Blue Shield

As part of its continuing public education program on drug abuse, Blue Shield is aiming at a new age group, 4-8, with a children's book entitled "Happy Valley and the Drug Witch", and an animated film based on the booklet. The film and booklet are expected to be available for local distribution by the end of November.

According to Mr. Ned Parish, NABSP President: "The very young have been largely neglected in drug abuse education. We believe the new booklet and film will be good attitude conditioning tools. They are not designed to teach children about drug abuse, but to bring home the fact that dope is bad for boys and girls. More sophisticated educational materials are available to students as they reach advance levels in school."

Initially, the six-minute animated film will be offered to television stations, then to schools, churches, day camps, and other interested groups. Both booklet and film will be available through the Public Relations Department, Blue Shield Plan of Illinois Medical Service, 233 North Michigan Avenue, Chicago, Illinois 60601.

IMPORTANT NOTICE
Change of Address

As of October 16, Blue Cross' and Blue Shield's Headquarters will move to 233 North Michigan Avenue in the Illinois Center complex. We will appreciate it if you will change your records to show this address for correspondence with all departments.

Those of you who contact us by phone will be pleased to know that all telephone numbers will remain the same, whether they are "direct dial" or switchboard numbers.

We are looking forward to serving you from our new Headquarters.

ASK BLUE SHIELD
. . . ABOUT MEDICARE

HOSPITAL VISIT DATA REQUIRED

Physicians submitting claims for hospital visits to Medicare beneficiaries must make sure that there is an entry on the hospital record for each patient, indicating the *date* of each visit.

If documentation of the visit is lacking, either the physician or the patient may, at some future date, be asked to refund Medicare payments already made. Although Medicare carriers are not necessarily required to check hospital records before paying such claims, questions may be raised subsequently about billed visits, perhaps as the result of a beneficiary's complaint. If a review of the hospital records does not show documentation the claim may have to be denied.

A hospital rule that physicians are to visit their patients daily is not considered sufficient evidence that such visits were in fact made. Acceptable evidence is the physician's progress notes on the hospital record for the day of the visit, or the nurse's notes indicating that he visited the patient on that day. The patient's statement that a visit was made is acceptable when taken within a reasonable time after the visit. Entries in the physician's own office records should not be considered as strong evidence as the hospital record.

Acceptance of Assignment

When a physician and his patient agree to the assignment method of billing, the physician agrees that the reasonable charge determined by Part B Medicare regulations will be payment in full and that he will not bill the patient for any charges disallowed as "more than the allowable charge." The patient is responsible for 20% of the allowable charges (20% co-insurance), any amount applied to the Part B deductible, and any charge for services disallowed as non-covered by Part B Medicare.

The agreement to accept an assignment for one patient does not obligate the physician to accept the assignment for his other patients, nor for the patient for a later service.

Where a physician bills the patient directly, payment delays could be prevented if the physician or his office assistant completed the SSA 1490 for the patient and forwarded the completed form to the appropriate Part B Medicare carrier's office for processing.

Before payment can be made, the claim form, SSA 1490, Request for Medicare Payment, must be completed, *including the signatures of the patient and physician on every assignment claim.* Be sure to check "I accept assignment" box (item #12), to show that the physician and his patient have agreed to the assignment. If the box is not checked, payment will be made to the patient.

Services of Physicians' Assistants

There is no provision under Part B Medicare which authorizes payment for services of Physicians' Assistants. The only basis for covering their services under Part B would be those furnished "incident to" a physician's professional service.

One of the requirements that must be met is that services are of the kind commonly furnished in physicians' offices. This limits coverage to services of nurses and other office assistants necessary to the physicians' in-office service. Thus, the performance by a physician's assistant of services which traditionally have been reserved to physicians cannot be billed, even though all the other incident-to requirements are met.

The physician might render a service which is covered *even though payment could not be made for the service rendered by the assistant.* For example, an office visit charge by the physician that included non-covered services by a physician's assistant, may be reimbursed if the physician himself sees the patient and also makes an independent evaluation of the patient's condition.

No Reimbursement for Acupuncture!

Acupuncture is a new agent of unknown use and efficacy in the United States. Three units of the National Institutes of Health, the National Institute of General Medical Sciences, National Institute of Neurological Diseases and Stroke, and Fogarty International Center have been designated to assess and identify specific opportunities and needs for research attending the use of acupuncture for surgical anesthesia and relief of chronic pain. Until the pending scientific assessment of the technique has been completed, and its efficacy established, Medicare payment for acupuncture may not be made.

SSA Changes in Laboratory Certification

The following laboratory has been certified for Medicare participation by the Social Security Administration:

HAVEN LABORATORY
103 Haven Road
Elmhurst, Illinois 60126

IMJ illinois medical journal

volume 142, number 4 october, 1972

staff

editor Theodore R. Van Dellen, M.D.
managing editor Richard A. Ott
assistant editor Joyce Sevits
executive administrator Roger N. White

annual reference issue

ISMS organization 300
Constitution and bylaws 304
Index 315
Policy manual 316
AMA delegates 325
ISMS delegates 326
Officers of county medical societies 327
Trustee districts 333
Councils of ISMS 336
Organization chart 335
Free standing committees 345
ISMS services 348
Ancillary organizations 358
Medical and paramedical education 362
Illinois state government 369
Medical legal 405

(Index to reference issue, page 412)

features

the presidents page 276
new pharmaceutical specialties 420
doctors news 424
what goes on 429
practice management 430
the view box 431
ekg of the month 432
editorial 433
obituaries 436

(Cover by Mike White Associates)

Microfilm copies of current as well as some back issues of the *Illinois Medical Journal* may be purchased from Xerox University Microfilms, 300 North Zeeb Road, Ann Arbor, Mich. 48106.

Published monthly by the Illinois State Medical Society, 360 N. Michigan Ave., Chicago, Ill., 60601. Copyright, 1972, The Illinois State Medical Society.

Subscription $5.00 per year, in advance, postage prepaid, for the United States, Cuba, Puerto Rico, Philippine Islands and Mexico. $7.50 per year for all foreign countries included in the Universal Postal Union. Canada $5.50 U.S. Single current copies available at 75c.

Second class postage paid at Chicago, Ill. and at additional mailing offices. When moving please notify Journal office of new address including old mailing label with notification, if possible. POSTMASTER: Send notice on form No. 3579 to Illinois State Medical Society, 360 N. Michigan Ave., Chicago, Ill. 60601.

Pharmaceutical advertising must be approved by the ISMS Publications Committee. Other advertising accepted after review by Publications Committee or Board of Trustees. All copy or plates must reach the Journal office by the fifteenth of the month preceding publication. Rates furnished upon request.

'Original articles will be considered for publication with the understanding that they are contributed only to the Illinois Medical Journal. The ISMS denies responsibility for opinions and statements expressed by authors or in excerpts, other than editorial or allied views or statements which reflect the authoritative action of the ISMS or of reports on official actions, policies or positions. Views expressed by authors do not necessarily represent those of the Society; any connection with official policies is coincidental.

REGISTERED AIA MEDIA DATA FORM

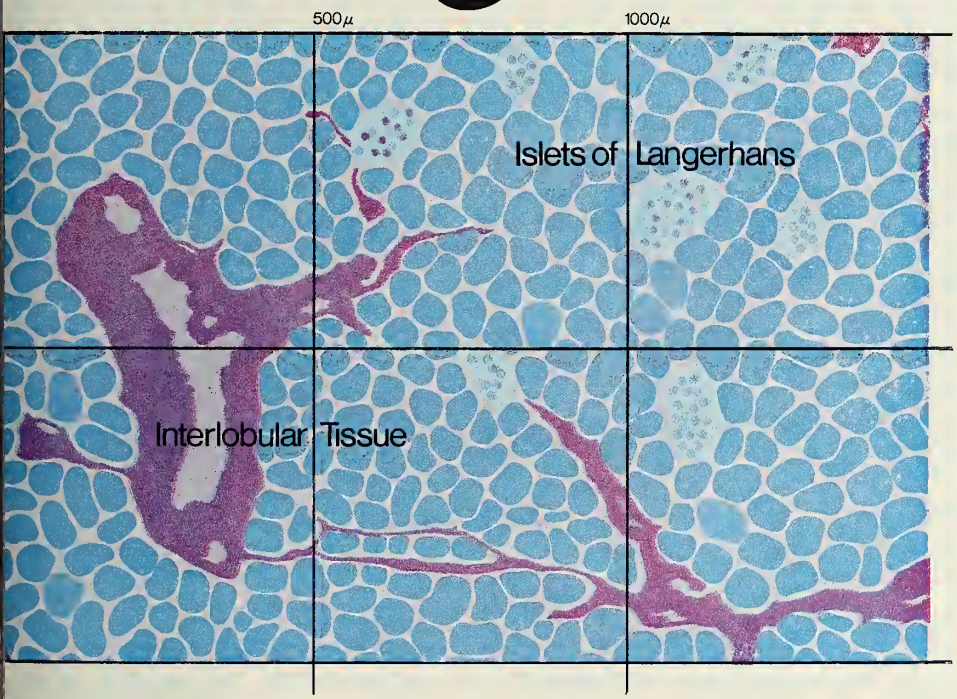

When irritable colon feels like this

in the presence of azotemia or in any clinical situation that predisposes to sustained hypotension that could lead to lactic acidosis. To differentiate lactic acidosis from ketoacidosis, periodic determinations of ketones in the blood and urine should be made in diabetics previously stabilized on phenformin, or phenformin and insulin, who have become unstable. If electrolyte imbalance is suspected, periodic determinations should also be made of electrolytes, pH, and the lactate-pyruvate ratio. The drug should be withdrawn and insulin, when required, and other corrective measures instituted immediately upon the appearance of any metabolic acidosis.
3. *Hypoglycemia:* Although hypoglycemic reactions are rare when phenformin is used alone, every precaution should be observed during the dosage adjustment period particularly when insulin or a sulfonylurea has been given in combination with phenformin.
Adverse Reactions: Principally gastrointestinal; unpleasant metallic taste, continuing to anorexia, nausea and, less frequently, vomiting and diarrhea. Reduce dosage at first sign of these symptoms. In case of vomiting, the drug should be immediately withdrawn. Although rare, urticaria has been reported, as have gastrointestinal symptoms such as anorexia, nausea and vomiting following excessive alcohol intake.
(B) 98-146-103-D (6/72)

For complete details, including dosage, please see full prescribing information.

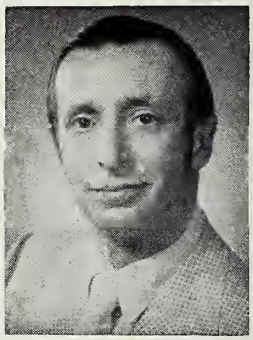
GEIGY Pharmaceuticals
Division of CIBA-GEIGY Corporation
Ardsley, New York 10502

of Langerhans?



Before using DBI-TD or any oral hypoglycemic, please read the prescribing information concerning dosage, warnings, contraindications, precautions and adverse reactions.

the presidents page



Now is the Time!

Within a few weeks of the time you receive this YOU will have an opportunity to help shape destiny.

Medicine today is at a crossroad, with a fork in the road and vague directional signs. Some of the signs are indistinct, while others have an excess of verbiage.

How do we decide the direction we should take? How do we find someone who will help us along what we feel is the correct road (and the proper person to enforce the speed limit)?

What I'm getting at is that election day is close at hand. On November 7, thousands of individuals will be elected to represent the people, to make and enforce laws, and to establish public policy.

It is the right, privilege and duty of every elector to cast a ballot for the individual he feels will be most representative.

Yes, medicine IS at a crossroad—but each branch has additional forks. We hear about guaranteed income plans, national health insurance, HMOs, free social services, expanded government-funded clinic and pre-paid programs. Then there is relicensure on the horizon, regulation of the practice of medicine, intrusions into the physician/patient relationship. And what about fee-for-service, freedom of choice by patient and physician, personal health insurance?

Who is going to design the directional signs to guide our state and national policies onto the proper course?

Now, I don't care if you're a Democrat or a Republican. There are excellent individuals and candidates in each party, individuals who have the welfare and well-being of the public in mind. They should be supported—regardless of party affiliation, or any other label attached. Identify them, support them, tell others about them, vote for them.

Let's get the proper sign painters and traffic cops in our system—to guide us at a correct pace, who will reflect our wishes in the area of health care delivery. Let's not have the socialistic-bureaucratic-planners take over in our area of expertise!

These *are* hard times for medicine; physicians are taking their lumps for unrealistic and baseless reasons. Suspicion and lack of trust abound, because the public is not getting a correct or complete enough picture of modern medicine. As Thomas Paine said, "These are the times that try men's souls. The summer soldier and the sunshine patriot will, in the hour of crisis, shrink from the service of his country. But he that is dedicated to what is right will long endure."

Let's not be summer soldiers. Let's not get headed in the wrong direction. Let's work diligently to elect those who will properly guide our country's destiny, especially as this relates to medicine and health. Let's move forward with good elected representatives.

We can not sit back in silence and watch the scenery, and let current trends continue. There is too much at stake. We *must* make a positive and constructive contribution to the issues that confront us.

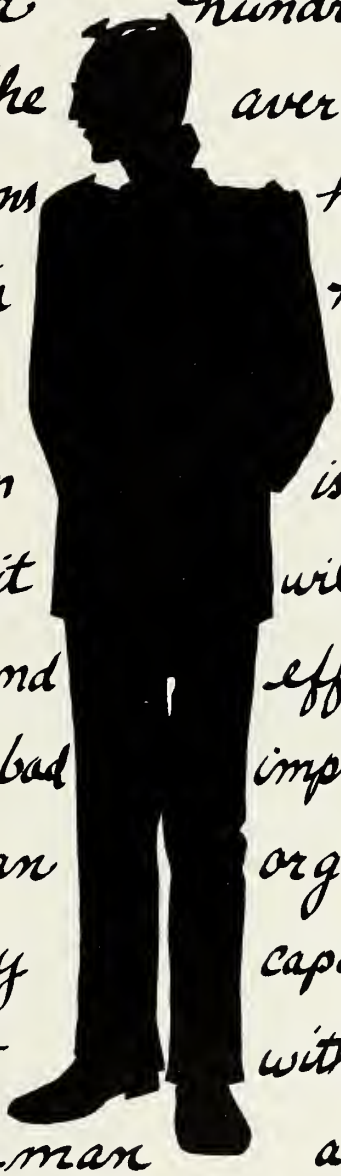
Are we going to be drivers or hitchhikers?

NOW is the time . . . exercise your prerogative . . . VOTE November 7!

For as Louis D. Brandeis said, "Experience should teach us to be more on our guard to protect our liberties when the Government's purposes are beneficent . . . the greatest dangers to liberty lurk in insidious encroachment by men of zeal, well meaning but without understanding."

Frank J. Jirka Jr. M.D.

An institution may spread itself over the entire world and may employ a hundred thousand men but the average person usually forms his judgment of it through his contact with one individual. If this person is rude or inefficient, it will take a lot of kindness and efficency to overcome the bad impression. Every member of an organization who in any capacity comes in contact with the public is a salesman and the impression he makes is an advertisement — good or bad!



IMJ
Illinois Medical Journal
Vol. 142, No. 4, October, 1972

ISMS ORGANIZATION

History of Founding and Expansion

Twenty-nine physicians met in Springfield June 4, 1850, to organize on a permanent basis the Illinois State Medical Society, which had been started informally 10 years earlier. The founders were concerned with the solution of ethical, scientific, legislative and economic problems. The first Constitution and Bylaws and the first Code of Medical Ethics were adopted; the first legislative committee was appointed, and a resolution outlining the beginnings of interprofessional relations was approved.

The Legislative Committee was instructed to "memorialize the legislature at its next session, praying the enactment of a statute providing for the registration of Births, Deaths and Marriages." The resolution ruled that "members of the Society will discourage the sale of patent or secret nostrums on the part of Druggists and Apothecaries throughout the State, and will patronize insofar as practicable, only those who abstain from the sale of such patent or secret nostrums."

The first full time secretary of the Society was Dr. Harold M. Camp who served for over 35 years until his death in 1958. The first executive administrator, Robert L. Richards, was employed at the time the office was moved to Chicago in 1960 and served until February, 1966. After an interim service by Dr. George F. Lull, Mr. Roger N. White was selected as Executive Administrator in May, 1968.

The Society published the early transactions in book form presenting not only the minutes of the House of Delegates, but also all scientific papers given at each annual convention. In 1898 a new era of communications began, for at that time, the *Illinois Medical Journal* was established and became the first "official organ of the Society."

Dr. G. N. Kreider was its first editor and served until 1913, followed by Dr. Clyde D. Pence with Dr. Henry G. Olds as the first managing editor. Dr. Charles G. Whalen became editor in 1919 and he and Dr. Olds served until they died in 1940. Dr. Camp followed Dr. Whalen, and Dr. Theodore R. Van Dellen is the editor today.

Dr. Whalen spearheaded many important activities in medicine, and has been called "the outstanding champion of the medical profession in its economic contacts." He has been credited as one of the first medical editors to blast "the socialization of medicine in this country." In 1922 he wrote extensively on state medicine, workmen's compensation, compulsory health insurance, free hospitalization and federal aid.

The first Fifty Year Club in the United States was announced by the *Illinois Medical Journal* in 1938.

The fourth largest medical society in the country has developed from these embryonic beginnings. This edition of the *Illinois Medical Journal* offers you an opportunity to contrast the extensive services available to the membership today with those offered in the past.

OFFICERS AND PLACES OF MEETING

Year	President	Secretary	Treasurer	Meeting Place
1840	John Todd	David Prince		Springfield
1850	Rudolph Rouse	Edwin G. Meek		Springfield
1850	William B. Herrick	Edwin G. Meek	Jno. Halderman	Springfield
1851	Samuel Thompson	H. Shoemaker	R. Rouse	Peoria
1852	Rudolph Rouse	E. S. Cooper	Edw. Dickenson	Jacksonville
1853	Daniel Brainerd	H. A. Johnson	A. B. Chambers	Chicago
1854	C. N. Andrews	H. A. Johnson	N. S. Davis	LaSalle
1855	N. S. Davis	E. Andrews	J. V. Z. Blaney	Bloomington
1856	H. Noble	N. S. Davis	J. V. Z. Blaney	Vandalia
1857	C. Goodbreak	H. A. Johnson	J. V. Z. Blaney	Chicago
1858	H. A. Johnson	N. S. Davis	J. W. Freer	Rockford
1859	David Prince	N. S. Davis	J. W. Freer	Decatur
1860	Wm. M. Chambers	N. S. Davis	J. W. Freer	Paris
1863	A. McFarland	N. S. Davis	J. H. Hollister	Jacksonville
1864	A. H. Luce	N. S. Davis	J. H. Hollister	Chicago
1865	J. M. Steele	N. S. Davis	J. H. Hollister	Bloomington
1866	F. F. Haller	N. S. Davis	J. H. Hollister	Decatur
1867	H. Noble	N. S. Davis	J. H. Hollister	Springfield
1868	S. T. Trowbridge	N. S. Davis	J. H. Hollister	Quincy
1869	S. T. Trowbridge	T. D. Fitch	J. H. Hollister	Chicago
1870	J. V. Z. Blaney	T. D. Fitch	J. H. Hollister	Dixon
1871	G. W. Albin	T. D. Fitch	J. H. Hollister	Peoria
1872	J. O. Hamilton	T. D. Fitch	J. H. Hollister	Rock Island
1873	D. W. Young	T. D. Fitch	J. H. Hollister	Bloomington
1874	T. F. Worrell	T. D. Fitch	J. H. Hollister	Chicago
1875	J. H. Hollister	T. D. Fitch	Wm. E. Quine	Jacksonville
1876	T. D. Washburn	N. S. Davis	J. H. Hollister	Urbana
1877	T. D. Fitch	N. S. Davis	J. H. Hollister	Chicago
1878	J. L. White	N. S. Davis	J. H. Hollister	Springfield
1879	E. P. Cook	N. S. Davis	J. H. Hollister	Lincoln
1880	Ephraim Ingalls	N. S. Davis	J. H. Hollister	Belleville
1881	G. W. Jones	S. J. Jones	J. H. Hollister	Chicago
1882	Robert Boal	S. J. Jones	J. H. Hollister	Quincy
1883	A. T. Darrah	S. J. Jones	J. H. Hollister	Peoria
1884	E. Andrews	S. J. Jones	Walter Hay	Chicago
1885	D. S. Booth	S. J. Jones	Walter Hay	Springfield
1886	Wm. A. Byrd	S. J. Jones	Walter Hay	Bloomington
1887	Wm. T. Kirk	D. W. Graham	Walter Hay	Chicago
1888	Wm. O. Ensign	D. W. Graham	Walter Hay	Rock Island
1889	C. W. Earle	D. W. Graham	T. W. McIlvaine	Jacksonville
1890	John Wright	D. W. Graham	T. W. McIlvaine	Chicago
1891	Jno. P. Mathews	D. W. Graham	Geo. N. Kreider	Springfield
1892	Charles C. Hunt	D. W. Graham	Geo. N. Kreider	Vandalia
1893	E. Fletcher Ingals	D. W. Graham	Geo. N. Kreider	Chicago
1894	Otho B. Will	J. B. Hamilton	Geo. N. Kreider	Decatur
1895	Daniel R. Brower	J. B. Hamilton	Geo. N. Kreider	Springfield
1896	D. W. Graham	J. B. Hamilton	Geo. N. Kreider	Ottawa
1897	A. C. Corr	J. B. Hamilton	Geo. N. Kreider	East St. Louis
1898	J. N. G. Carter	E. W. Weis	Geo. N. Kreider	Galesburg
1899	J. T. Pitner	E. W. Weis	Geo. N. Kreider	Cairo
1900	H. N. Moyer	E. W. Weis	Geo. N. Kreider	Springfield
1901	G. N. Kreider	E. W. Weis	E. J. Brown	Peoria
1902	J. T. McAnally	E. W. Weis	E. J. Brown	Quincy
1903	M. L. Harris	E. W. Weis	E. J. Brown	Chicago
1904	C. E. Black	E. W. Weis	E. J. Brown	Bloomington
1905	W. E. Quine	E. W. Weis	E. J. Brown	Rock Island
1906	H. C. Mitchell	E. W. Weis	E. J. Brown	Springfield
1907	J. F. Percy	E. W. Weis	E. J. Brown	Rockford
1908	W. L. Baum	E. W. Weis	E. J. Brown	Peoria
1909	J. W. Pettit	E. W. Weis	E. J. Brown	Quincy
1910	J. L. Wiggins	E. W. Weis	E. J. Brown	Danville
1911	A. C. Cotton	E. W. Weis	E. J. Brown	Aurora
1912	W. K. Newcomb	E. W. Weis	E. J. Brown	Springfield
1913	L. H. A. Nickerson	E. W. Weis	A. J. Markley	Peoria

Year	President	Secretary	Treasurer	Meeting Place
1914	Charles J. Whalen	W. H. Gilmore	A. J. Markley	Decatur
1915	A. L. Brittin	W. H. Gilmore	A. J. Markley	Springfield
1916	C. W. Lillie	W. H. Gilmore	A. J. Markley	Champaign
1917	W. L. Noble	W. H. Gilmore	A. J. Markley	Bloomington
1918	E. B. Coolley	W. H. Gilmore	A. J. Markley	Springfield
1919	E. W. Fiegenbaum	W. H. Gilmore	A. J. Markley	Peoria
1920	J. W. Van Derslice	W. H. Gilmore	A. J. Markley	Rockford
1921	W. F. Grinstead	W. H. Gilmore	A. J. Markley	Springfield
1922	Charles Humiston	W. H. Gilmore	A. J. Markley	Chicago
1923	E. P. Sloan	W. D. Chapman	A. J. Markley	Decatur
1924	E. H. Ochsner	W. D. Chapman	A. J. Markley	Springfield
1925	L. C. Taylor	H. M. Camp	A. J. Markley	Quincy
1926	J. C. Krafft	H. M. Camp	A. J. Markley	Champaign
1927	Mather Pfeiffenberger	H. M. Camp	A. J. Markley	Moline
1928	G. Henry Mundt	H. M. Camp	A. J. Markley	Chicago
1929	J. E. Tuite	H. M. Camp	A. J. Markley	Peoria
1930	F. O. Fredrickson	H. M. Camp	A. J. Markley	Joliet
1931	Wm. D. Chapman	H. M. Camp	A. J. Markley	East St. Louis
1932	R. R. Ferguson	H. M. Camp	A. J. Markley	Springfield
1933	John R. Neal	H. M. Camp	A. J. Markley	Peoria
1934	Philip H. Kreuscher	H. M. Camp	A. J. Markley	Springfield
1935	Charles D. Center*			
1935	Charles S. Skaggs	H. M. Camp	A. J. Markley	Rockford
1936	Chas. B. Reed	H. M. Camp	A. J. Markley	Springfield
1937	Rolland L. Green	H. M. Camp	A. J. Markley	Peoria
1938	R. K. Packard	H. M. Camp	A. J. Markley	Springfield
1939	S. E. Munson	H. M. Camp	A. J. Markley	Rockford
1940	Jas. H. Hutton	H. M. Camp	A. J. Markley	Peoria
1941	J. S. Templeton	H. M. Camp	A. J. Markley	Chicago
1942	Chas. H. Phifer	H. M. Camp	H. M. Camp	Springfield
1943	E. H. Weld	H. M. Camp	H. M. Camp	Chicago
1944	G. W. Post**	H. M. Camp	H. M. Camp	Chicago
1945	E. P. Coleman	H. M. Camp	H. M. Camp	***
1946	E. P. Coleman	H. M. Camp	H. M. Camp	Chicago
1947	R. S. Berghoff	H. M. Camp	H. M. Camp	Chicago
1948	I. H. Neece	H. M. Camp	H. M. Camp	Chicago
1949	Percy E. Hopkins	H. M. Camp	H. M. Camp	Chicago
1950	Walter Stevenson	H. M. Camp	H. M. Camp	Springfield
1951	Harry M. Hedge	H. M. Camp	H. M. Camp	Chicago
1952	C. Paul White	H. M. Camp	H. M. Camp	Chicago
1953	Leo P. A. Sweeney	H. M. Camp	H. M. Camp	Chicago
1954	Willis I. Lewis	H. M. Camp	H. M. Camp	Chicago
1955	Arkell M. Vaughn	H. M. Camp	H. M. Camp	Chicago
1956	F. Garm Norbury	H. M. Camp	H. M. Camp	Chicago
1957	F. Lee Stone	H. M. Camp	H. M. Camp	Chicago
1958	Lester S. Reavley	H. M. Camp	H. M. Camp	Chicago
1959	Raleigh C. Oldfield	H. M. Camp	H. M. Camp	Chicago
1960	Joseph T. O'Neill	George F. Lull	George F. Lull	Chicago
1961	H. Close Hesseltine	Jacob E. Reisch	Jacob E. Reisch	Chicago
1962	Edwin S. Hamilton	Jacob E. Reisch	Jacob E. Reisch	Chicago
1963	George F. Lull	Jacob E. Reisch	Jacob E. Reisch	Chicago
1964	Harlan English	Jacob E. Reisch	Jacob E. Reisch	Chicago
1965	Edward A. Piszczek	Jacob E. Reisch	Jacob E. Reisch	Chicago
1966	Burtis E. Montgomery	Jacob E. Reisch	Jacob E. Reisch	Chicago
1967	Caesar Portes	Jacob E. Reisch	Jacob E. Reisch	Chicago
1968	Newton DuPuy	Jacob E. Reisch	Jacob E. Reisch	Chicago
1969	Philip G. Thomsen	Jacob E. Reisch	Jacob E. Reisch	Chicago
1970	Edward W. Cannady	Jacob E. Reisch	Jacob E. Reisch	Chicago
1971	J. Ernest Breed	Jacob E. Reisch	Jacob E. Reisch	Chicago
1972	L. T. Fruin****	Jacob E. Reisch	Jacob E. Reisch	Chicago
1973	Frank J. Jirka, Jr.	Jacob E. Reisch	Jacob E. Reisch	Chicago

*Died before induction into office
**Died in office. Term completed by Robert S. Berghoff, First Vice President
***Meeting cancelled 1945
****Died in office. Term completed by C. J. Jannings, First Vice President

Principles Of Medical Ethics

PREAMBLE: These principles are intended to aid physicians individually and collectively in maintaining a high level of ethical conduct. They are not laws but standards by which a physician may determine the propriety of his conduct in his relationship with patients, with colleagues, with members of allied professions, and with the public.

SECTION 1—The principal objective of the medical profession is to render service to humanity with full respect for the dignity of man. Physicians should merit the confidence of patients entrusted to their care, rendering to each a full measure of service and devotion.

SECTION 2—Physicians should strive continually to improve medical knowledge and skill, and should make available to their patients and colleagues the benefits of their professional attainments.

SECTION 3—A physician should practice a method of healing founded on a scientific basis; and he should not voluntarily associate professionally with anyone who violates this principle.

SECTION 4—The medical profession should safeguard the public and itself against physicians deficient in moral character or professional competence. Physicians should observe all laws, uphold the dignity and honor of the profession and accept its self-imposed disciplines. They should expose, without hesitation, illegal or unethical conduct of fellow members of the profession.

SECTION 5—A physician may choose whom he will serve. In an emergency, however, he should render service to the best of his ability. Having undertaken the care of a patient, he may not neglect him; and unless he has been discharged he may discontinue his services only after giving adequate notice. He should not solicit patients.

SECTION 6—A physician should not dispose of his services under terms or conditions which tend to interfere with or impair the free and complete exercise of his medical judgment and skill or tend to cause a deterioration of the quality of medical care.

SECTION 7—In the practice of medicine a physician should limit the source of his professional income to medical services actually rendered by him, or under his supervision, to his patients. His fee should be commensurate with the services rendered and the patient's ability to pay. He should neither pay nor receive a commission for referral of patients. Drugs, remedies or appliances may be dispensed or supplied by the physician provided it is in the best interests of the patient.

SECTION 8—A physician should seek consultation upon request, in doubtful or difficult cases; or whenever it appears that the quality of medical service may be enhanced thereby.

SECTION 9—A physician may not reveal the confidences entrusted to him in the course of medical attendance, or the deficiencies he may observe in the character of patients, unless he is required to do so by law or unless it becomes necessary in order to protect the welfare of the individual or of the community.

SECTION 10—The honored ideals of the medical profession imply that the responsibilities of the physician extend not only to the individual, but also to society where these responsibilities deserve his interest and participation in activities which have the purpose of improving both the health and the well-being of the individual and the community.

Constitution And Bylaws

Adopted, 1903
As Amended, 1972

CONSTITUTION

ARTICLE I. NAME

The name and title of this organization shall be the Illinois State Medical Society.

ARTICLE II. PURPOSES OF THE SOCIETY

The purposes of this Society are to promote the science and art of medicine, to protect the public health, to elevate the standards of medical education and to unite the medical profession behind these purposes; to promote similar interests in the component societies and to unite with similar organizations in other states and territories of the United States to form the American Medical Association. The Society shall inform the public and the profession concerning the advancements in medical science and the advantages of proper medical care.

ARTICLE III. COMPONENT SOCIETIES

Component societies shall consist of those county medical societies which hold charters from this Society.

ARTICLE IV. COMPOSITION OF THE SOCIETY

The Society shall consist of active members and such other members as the Bylaws may provide.

ARTICLE V. HOUSE OF DELEGATES

Section 1. The House of Delegates shall be the legislative body of the Illinois State Medical Society, and unless otherwise herein provided, its deliberations shall be binding upon the officers, including the Board of Trustees. The House of Delegates shall set the basic policy and philosophy of the Society.

Section 2. The House of Delegates shall elect the general officers, except as otherwise provided in the Bylaws.

ARTICLE VI. BOARD OF TRUSTEES

The Board of Trustees, whose duties are executive and judicial, shall have charge of all property and all financial affairs of the Society, and shall perform such other duties as are prescribed by law governing the directors of corporations, or as may be prescribed in the Bylaws.

ARTICLE VII. CONVENTIONS AND MEETINGS

The Society shall hold an annual convention during which there shall be a business meeting of the House of Delegates and general scientific meetings which shall be open to all registered members.

ARTICLE VIII. OFFICERS

The officers of this Society shall be a president, a president-elect, a first vice president, a second vice president, a secretary-treasurer, a speaker and vice speaker of the House of Delegates, nineteen trustees and one trustee at large, and such other officers as the Bylaws may provide.

ARTICLE IX. THE SEAL

This Society shall have a common seal with power to break, change or renew the same when necessary.

ARTICLE X. AMENDMENTS

The House of Delegates may amend this Constitution at any annual business meeting of the House of Delegates provided that the amendment shall have been proposed at the preceding annual business meeting, and that two-thirds of the members of the House of Delegates seated concur in the amendment.

BYLAWS

CHAPTER I. MEMBERSHIP

Section 1. *Members.* Members shall consist of Regular members, Provisional members, Associate members, Emeritus members, Retired members, Service members, Distinguished members, In-training members and Student members. Members enjoy full rights and privileges, including the right to vote and hold office and are counted in determining the strength of the Society's Delegation to the American Medical Association.

A. *Regular members.* Regular members shall be those physicians licensed to practice medicine in all its branches in the State of Illinois, who are residents of the State of Illinois, persons of good moral character and professional standing and members of their component society.

B. *Provisional members.* Provisional membership shall be available to any Illinois physician who has made a declaration of intention to become a citizen of the United States, who has received a license in this State to practice medicine in all of its branches, and who—with the exception of United States citizenship—possesses all of the qualifications for membership prescribed by these Bylaws. Provisional membership shall terminate one year after the expiration of the minimum period of time within which such member could have perfected his citizenship. After obtaining full citizenship and prior to the expiration of his provisional membership, such member may be, upon application to his component medical society, transferred to regular membership.

C. *Associate members.* Associate members are physicians who hold the degree of Doctor of Medicine, who have a hospital permit to practice medicine in the State of Illinois and are members of their component medical society.

D. *Emeritus members.* Emeritus members are those who have been regular members in good standing for thirty-five years, have reached or will have reached the age of seventy before the next fiscal year of the Society, have made written application to their component society and have been recommended by their component society for emeritus status. Such membership shall be effective January first of the year following election. Credit for membership in other American Medical Association constituent societies shall be accorded transferees, provided they have been members of this Society for at least five years.

E. *Retired members.* Retired members shall consist of those who have been regular members and who by reason of age or incapacity have retired from active practice and who upon application and recommendation from their component society have been made retired members.

F. *Service members.* Physicians serving as medical officers in the United States Governmental Services, who are members of a component society, so long as they are engaged actively fulltime in their respective service, and thereafter if they have been retired on account of age or physical disability, shall be elected to service membership. Physicians serving as full-time employees at the headquarters of the American Medical Association shall be eligible for service membership following approval and recommendation by their component medical society. Membership in this classification shall terminate on cessation of active duty.

G. *Distinguished members.* Physicians of Illinois or other states or foreign countries who have risen to prominence in the profession, teachers of medicine or of the sciences allied to medicine, not eligible for regular membership, or members of associated arts and sciences, who have made significant contributions to medicine may be nominated by any member of the House of Delegates and may be elected by the House at any annual convention by a two-thirds affirmative vote of those present and voting. They shall not be considered as members in determining the number of delegates to the American Medical Association, but they may participate in all other society activities.

H. *In-Training members.* In-training members are persons who are medical school graduates, of good moral character and professional standing and serving an internship or residency approved by the American Medical Association in the State of Illinois. They must be recommended for membership by two members of this Society who are also members of the hospital staff where the candidate is in training. Membership shall end at the end of the year in which training is terminated. Following this, in-training members may apply for regular membership through their component society.

I. *Student members.* Student members are those who have been accepted for the second year or higher in an Illinois medical school, are members of the Student American Medical Association, are of good moral character, professional and academic standing and student members of a component medical society where provision has been made for this class of membership. Membership shall terminate upon graduation.

Section 2. *Discrimination of membership.* Membership in the Illinois State Medical Society shall not be denied or abridged because of color, creed, race, religion or ethnic origin.

Section 3. *Tenure and Termination.*

A. *Tenure of membership.* The name of a physician on a properly certified roster of members of a component society which has paid its annual assessments, shall be prima facie evidence of membership in this society. The member shall retain his membership so long as he complies with the provisions of this Constitution and Bylaws and with the Principles of Medical Ethics of the American Medical Association. A member shall hold only one type of membership at any one time.

B. *Termination of membership.* Any person who is under sentence of suspension, or expulsion from a component society shall not be entitled to any of the rights or benefits of this society nor shall he be permitted to take part in any of the proceedings until he has been reinstated. Non-payment of dues by May 1 of each year shall be grounds for termination of membership.

CHAPTER II. DUES, FUNDS AND ASSESSMENTS

Section 1. *Dues.* Annual dues may be levied by the House of Delegates on each class of membership. The amount of dues shall be recommended by the Board of Trustees and shall be fixed by the House of Delegates and shall include the dues and/or assessments approved by the House of Delegates of the American Medical Association. These shall include the annual subscription to the *Illinois Medical Journal* which shall be at least fifty percent of the regular subscription price of the *Journal.* Only Regular, Provisional, Associate, In-training and Student members shall be assessed annual dues. The dues shall be paid by the component society for its members prior to May 1 of each year.

Section 2. *Reduction and remission of dues.* The Board of Trustees upon recommendation of the component society, shall give fifty percent reduction in dues to teaching, research and administrative personnel in full-time employment in the approved medical schools in Illinois, or in similar not-for-profit institutions in Illinois. Physicians in private practice of medicine may be given a fifty percent reduction in dues during the first year of practice, upon recommendation of their component society. Physicians approved for membership after June 30 shall pay one-half the annual dues for that year. The Board of Trustees may authorize remission of dues of any member on recommendation of his component society for good reason. In such cases the secretary shall recommend remission of dues by the American Medical Association. Emeritus members, Retired members, Service members and Distinguished members are not required to pay dues.

Section 3. *Assessments and Funds.* In addition to dues, assessments may be made on dues-paying members on recommendation of the Board of Trustees and approval of the House of Delegates. Funds may be raised from publications of the Society and any other manner approved by the Board of Trustees. Funds may be appropriated by the Board of Trustees to be spent for the Society to carry on its publications, to encourage scientific

investigations, and for other purposes approved by the Board of Trustees.

CHAPTER III.

EDUCATIONAL AND SCIENTIFIC PROGRAMS

Educational and scientific programs shall be provided by the Society at such times and places as recommended by the Board of Trustees and approved by the House of Delegates.

CHAPTER IV. HOUSE OF DELEGATES

Section 1. *Composition.* The voting membership of the House of Delegates shall consist of 1) delegates elected by component societies and affiliated groups, 2) the President, 3) the President-elect, 4) the Vice Presidents, 5) the Secretary-Treasurer, 6) the Speaker and Vice Speaker, and 7) Trustees. Past trustees, past presidents, past speakers, general officers of the American Medical Association, and delegates and alternate delegates from the Illinois State Medical Society to the American Medical Association may have the privilege of the floor without vote.

Section 2. *Delegates.* Each component society shall be entitled to send one of its members to the House of Delegates each year, for each seventy-five members, not to include student members, and one for a major fraction thereof, but each component society which has made its annual report and paid its assessment as provided for in this Constitution and Bylaws shall be entitled to one delegate. The number of delegates to which any component society is entitled shall be determined by the number of members of the component society on membership rolls of the Illinois State Medical Society as of December 31 of the preceding year. The term of office of a delegate shall begin January first following his election and shall be for two years, or until his successor has been elected. Component societies with only one delegate may elect for one year.

Section 3. *Affiliate Group Delegates.* The combined Illinois chapters of the Student American Medical Association shall be considered a single affiliate group and shall be entitled to one student delegate with vote, and one student alternate delegate to serve in the House of Delegates. Each delegate shall be considered as an Affiliated Group Member of the Illinois State Medical Society. The term of office shall begin January first following his election and shall be for two years, or until his successor is elected.

Section 4. *Time and Place of Meeting.* The House of Delegates shall meet annually at such time and place as it shall determine.

Section 5. *Quorum.* Fifty delegates representing no less than twenty component societies shall constitute a quorum for the transaction of business.

Section 6. *Special meetings.* Special meetings of the House of Delegates may be called by a majority of the Board of Trustees or upon petition of twenty component societies. When a special meeting is called, the secretary shall mail a notice to the last known address of each member of the House of Delegates at least ten days before the special meeting is to be held. The notice shall specify the time and place of the meeting and the purpose for which the meeting is called. The meeting shall not consider any business except that for which it was called.

Section 7. *Registration.* Before being seated at any annual or special session, each delegate or his alternate shall deposit with the Reference Committee on Credentials a certificate signed by the President and/or the Secretary of his component society stating that the delegate or alternate has been regularly elected to the House of Delegates. A delegate or his alternate may be seated without credentials, provided he is properly identified and is certified to the secretary of the Illinois State Medical Society. Whenever a delegate or his alternate are unable to attend a particular meeting, the component society may select and certify a substitute delegate who shall have the same powers and duties as did the delegate. A delegate whose credentials have been accepted by the Reference Committee on Credentials and whose name has been placed on the roll of the House, shall remain a delegate until the final adjournment of that session. If a delegate, once seated, is unable to be present for reasons acceptable to the Committee on Credentials, an alternate may be certified by the committee. After the alternate has been seated, he cannot be replaced for that session.

Section 8. *District Division.* The House of Delegates shall divide the state into districts, specifying which counties each district shall include.

Section 9. *Order of Procedure.* The order of business of the House of Delegates shall be determined by the Speaker, subject to approval by the Reference Committee on Rules and Order of Business. Sturges Standard Code of Parliamentary Procedure, Current Edition, shall be the guide for all procedure when not in conflict with the Constitution and Bylaws.

Section 10. *Privilege of the Floor.* The House of Delegates by two-thirds vote of those present and voting, may extend an invitation to address the House to any person who in its judgment might assist in its deliberations.

Section 11. *Introduction of Resolutions and Other Business.* All resolutions must be introduced by a voting member of the House. Resolutions to be printed in the handbook must be submitted nine weeks prior to the annual meeting. Resolutions to be mailed to the delegates prior to the annual meeting must be submitted to ISMS headquarters four weeks prior to the annual meeting. Resolutions submitted after the above date must be approved by the Speaker, Vice Speaker and one delegate from CMS and one from outside CMS or by a two-thirds vote of the House of Delegates before they will be considered as business of the House. Reports of committees, councils and officers requiring action must submit recommendations to the House as a resolution for action. Reports, resolutions and requests for action after the opening of the first session of the House of Delegates shall require for consideration a two-thirds affirmative vote.

CHAPTER V. ELECTION OF OFFICERS

Section 1. *Officers.* The officers of this Society shall consist of the president, president-elect, first and second vice

presidents, secretary-treasurer, speaker and vice speaker, nineteen trustees and one trustee-at-large.

Section 2. *Elections.* All elections shall be by ballot except when there is only one candidate for a given office, then election may be by voice vote.

The majority of votes cast shall be necessary to elect.

The election of officers, delegates and alternate delegates to the AMA, shall follow the completion of action on current and old business at the final session of the House of Delegates.

Section 3. *Terms of Office.* The president-elect, vice-president, secretary-treasurer, the speaker and vice speaker shall be elected annually by the House of Delegates to serve for a term of one year.

Members of the Board of Trustees shall be elected by the House of Delegates to serve for a term of three years.

The speaker and vice speaker shall not be elected for more than three consecutive terms to their respective offices; they shall be elected from the membership of the House of Delegates.

The president-elect shall be inducted into the office of president by the retiring president during the final session of the House of Delegates. After assuming office at the adjournment of the annual business meeting, he shall continue in office until his successor has been elected and installed. Following his retirement as president, he shall automatically become a trustee-at-large for a term of one year.

CHAPTER VI. DUTIES OF OFFICERS

Section 1. *The President.* The president of the Illinois State Medical Society shall lead the Society in all its functions. He shall deliver an annual address at such time as may be arranged, and perform such other duties as custom and parliamentary usage may require.

Section 2. *The Vice Presidents.* The vice presidents shall act for and perform such duties for the president as he shall direct. They shall, when so acting, implement and advance the programs and policies of the president.

In the event of the president's death, resignation or removal from office, the first vice president shall succeed to the presidency.

In the event of a vacancy in the office of first vice president, the president shall fill the office by appointment.

Section 3. *Successor to President-Elect.* In the case of death, resignation, or removal from office of the president-elect, the office shall be filled by the House of Delegates at the next annual convention by election at a time recommended by the Reference Committee on Rules and Order of Business.

Section 4. *The Speaker.* The speaker, who shall be versed in paliamentary procedure, shall preside at the meetings of the House of Delegates and shall perform such duties as custom and parliamentary usage require.

He shall appoint all committees of the House of Delegates.

He shall seek the advice of officers and trustees.

He shall be an ex-officio member of the Committee on Constitution and Bylaws.

Section 5. *The Vice Speaker.* The vice speaker shall preside for the speaker in the latter's absence or at his request. In case of death, or resignation of the speaker, the vice-speaker shall serve during the unexpired term.

Section 6. *The Secretary-Treasurer.* In addition to the rights and duties ordinarily devolving on the secretary of a corporation by law, custom or parliamentary usage, and those granted or imposed in other provisions of the Constitution and these Bylaws, the secretary-treasurer shall be the official custodian of all securities and the income therefrom, owned by the Society, subject to the direction and disposition of the Board of Trustees. He shall be a member of the Finance Committee of the Board of Trustees.

The Board of Trustees may select a bank or trust company to act as custodian in the place of the secretary-treasurer, of all or any part of such securities and to act as agent of the Society in collecting the income therefrom.

He shall perform such other duties as may be directed by the House of Delegates or by the Board of Trustees.

In the event of a vacancy in the office of the secretary-treasurer, the Board of Trustees shall fill the vacancy until the next annual election.

CHAPTER VII. THE BOARD OF TRUSTEES

Section 1. *Composition.* The Board of Trustees shall consist of nineteen trustees elected by the House of Delegates [nine shall be chosen from district number three, and one from each of the other ten districts (see trustee district map on page 332), these districts of the geographical area as of May 1946], and one trustee-at-large (the retiring president, who shall serve a term of one year), the president, the president-elect, the speaker and secretary-treasurer.

The vice presidents and vice speakers shall attend the meetings (including executive sessions), with the right of discussion, but without the right to vote.

Section 2. *Duties.* The duties of the Board of Trustees are executive, custodial and judicial.

A. *Executive Duties.* The Board of Trustees shall implement all mandates from the House of Delegates except in matters of property or finance when it shall have sole authority.

The Board of Trustees may establish a not-for-profit corporation of physicians known as the Illinois Foundation for Medical Care.

The Board of Trustees may request a report from any committee in the interim between meetings of the House of Delegates.

B. *Custodial Duties.* The Board of Trustees shall have charge and control of all property of whatsoever nature belonging to the Society, and of all funds from whatsoever source belonging to the Society.

No person shall expend or use for any purpose money belonging to the Society without the approval of the Board of Trustees.

All money received by the Board of Trustees and its agents, resulting from the duties assigned them, shall be paid into the treasury of the Society, and all orders on the treasury for disbursement of money shall be approved by the Board.

The Board of Trustees shall formulate rules governing the expenditure of money to meet the necessary running expenses and fixed charges of the Society.

All acts of the House of Delegates involving the expenditure, appropriation or use in any manner of money, or the acquisition or disposal in any manner of property of any kind belonging to the Society, must

be approved by the Board of Trustees before same shall become effective.

Funds may be appropriated to encourage scientific investigation, medical education or any other purpose deemed proper and approved by the Board of Trustees.

C. *Judicial Duties.* The Board of Trustees shall be the board of censors of the Society. It shall have jurisdiction over all questions of ethics and in the interpretation of the laws of the Society. It shall consider all questions involving the rights and standing of members, whether in relation to other members, to component societies, or to this Society.

All questions of an ethical nature before the House of Delegates or the general scientific meetings, shall be referred to the Board of Trustees without discussion. The Board shall hear and decide all questions of procedure affecting the conduct of members on which an appeal is taken from the decision of a component society.

The decision of the Board of Trustees shall be final except that an appeal may be taken by a member charged with misconduct as provided for in the Constitution and Bylaws of the American Medical Association.

Section 3. *Executive Administrator.* The Board of Trustees shall employ an executive administrator (who, when he shall be a physician, may be designated as the executive vice-president) whose duties shall be determined by the Board. He shall be responsible to the chairman of the Board. The Board shall review at each of its meetings the interim activities of the administrator. The Board shall also employ such other people as are needed for the conduct of the affairs of the Society.

Section 4. *Meetings.* The Board of Trustees shall meet daily during the annual convention of the Society, and at such other times as necessity may require, subject to the call of the chairman, or on the petition of the majority of the Trustees.

Section 5. *Organization.*

A. *Chairman.* The Board of Trustees shall meet on the last day of the annual convention and elect from among its members a chairman. He shall hold office for one year and may succeed himself for one additional year.

B. *Duties of the Chairman.* The chairman of the Board of Trustees shall prepare an agenda and shall preside at all meetings of the Board. He shall make an annual report to the House of Delegates. He shall be chairman of the Executive Committee. He shall present the report of the actions of the Executive Committee to the Board.

Section 6. *Quorum.* Ten members of the Board of Trustees from at least seven districts shall constitute a quorum for the transaction of business.

Section 7. *County Societies.* The Board of Trustees shall have authority to organize the physicians of two or more counties into societies to be suitably designated, and these societies, when organized and chartered, shall be entitled to all rights and privileges provided for component societies until such counties shall be organized separately.

Section 8. *Publications.* The Board of Trustees shall provide and superintend the publication and the distribution of all proceedings, transactions and memoirs of the Society, and shall have authority to appoint an editor and such assistants as it deems necessary.

Section 9. *Bonding.* The Board of Trustees shall provide at the expense of the Society, adequate bond for those officers and employees of the Society it considers require bonding.

Section 10. *Duties of Trustees.* Each trustee shall be the organizer, consultant, advisor, administrator and speaker for the members of his district, and represent the Society as well as the members of his district at the Board meetings.

Each trustee should visit the societies in his district at least once a year. He shall make an annual report of his work and the condition of the profession in each society in his district to the Board of Trustees and to the House of Delegates.

Where his district is composed of more than one county, the trustee shall be an ex-officio member all district committees. He shall report to the Board of Trustees the actions of the component societies on reports of these committees.

The necessary traveling expenses incurred by such trustee in the line of the duties herein imposed, may be allowed by the Board of Trustees upon presentation of a properly itemized statement.

Section 11. *Vacancies.* If during the interval between two annual conventions, sickness, death, or removal from the state or district, or any other reason prevents a trustee from attending the duties of his district, or if he shall be absent from two consecutive meetings of the Board, his office may be declared vacant at the discretion of the Board. The Board shall have the authority to fill the vacancy for the period between the date at which the office was declared vacant and the next annual meeting of the House of Delegates.

Section 12. *The Benevolence Fund.* Each year the Board shall appropriate from the funds of this Society such sum or sums as it may deem proper to be held in a fund to be known as "The Benevolence Fund." This fund is established and shall be used only for the assistance or relief of needy members of this Society, their widows, widowers, or minor children. The assets shall be held in the treasury of this Society in a separate fund. Donations or bequests to the Benevolence Fund automatically become a part of these assets.

Section 13. *Audit and Financial Statement.* The Board of Trustees shall employ annually a certified public accountant to audit all accounts of the Society, and present a statement of same in its annual report to the House of Delegates.

This report shall also specify the character and cost of all publications of the Society during the year, and the amount of all other property belonging to the Society under its control, with such suggestions as it may deem necessary.

CHAPTER VIII. DISTRICT COMMITTEES

Each trustee district which is composed of more than one county, shall have an Ethical Relations Committee, a Peer Review Committee, and such other committees as required to provide to each component society, those

services the component society may not be able to provide for itself. District committees shall function only at the request of a component society within the district.

Complaints initially received by district committees shall be referred immediately to the component society for action.

District committees shall be governed by the procedural rules and regulations governing the counterpart state society committee or by these Bylaws.

Reports of findings and recommendations of these district committees shall be made to the component society which requested action.

The district trustee shall include a summary of the activities of each of these committees and the findings in general, in his annual report to the House of Delegates.

The committee members shall be elected at a meeting of the delegates of the district called by the trustee of the district, before or during the annual convention of the Illinois State Medical Society. Chairmen of the committees shall be designated by the trustee of the district, and the trustee shall be an ex-officio member of each committee.

CHAPTER IX. COMMITTEES

Section 1. *Committee Structure.* The committee structure of the Illinois State Medical Society shall be as follows:

A. Councils (standing committees)
B. House of Delegates Committees
C. Board of Trustees Committees
D. Ethical Relations Committee (chapter XI of these Bylaws)

Section 2. *Councils.*

A. The Medical-Legal Council shall be concerned in the areas of:
 1. Liaison with the Illinois Bar Association
 2. Liaison with courts, particularly where impartial medical testimony is involved.
 3. Implementation of the Impartial Medical Testimony Rule
 4. Legal aspects of medical practice other than in the area of mental health
 5. Licensing and standards of practice.
 6. Quackery
 7. Anatomical gifts and organ transplants

B. The Council on Governmental Affairs shall be concerned in the areas of:
 1. Federal and state legislation—analysis and communication
 2. Legislative liaison—both state and federal
 3. Political education

C. The Council on Education and Manpower shall be concerned in the areas of:
 1. Liaison with medical schools, curricula, etc.
 2. Health manpower and training
 3. Postgraduate education
 4. Internships, residencies, etc.
 5. Scientific assembly
 6. Student loans
 7. Liaison with Student American Medical Association
 8. Continuing Medical Education

D. The Council on Economics and Peer Review shall be concerned in the areas of:
 1. Relations with governmental purchase of care programs (Medicare, Medicaid, Vocational Rehabilitation, etc.)
 2. Relations with prepayment, insurance and other third party plans.
 3. Fees and fee adjudication as promulgated by the Health Care Financing Committee
 4. Health care cost and utilization
 5. Peer Review (Part 2 of Chapter XII of these Bylaws)

E. Council on Environmental and Community Health shall be concerned in the areas of:
 1. Governmental administrative regulation—Departments of Health
 2. Public Safety
 3. Occupational Health
 4. Child and School Health
 5. Pollution
 6. Nutrition

F. Council on Public Relations and Membership Services shall be concerned in the areas of:
 1. Publicity and promotion
 2. News media relations
 3. Exhibits and public service programming
 4. Religion and medicine
 5. Illinois State Medical Society sponsored membership insurance programs, Keogh Plans, etc.
 6. New member orientation and membership benefit explanation
 7. Fifty Year Club

G. Council on Mental Health and Addiction shall be concerned in the areas of:
 1. Facilities and services
 2. Liaison with Department of Mental Health
 3. Legal aspects of commitment, etc.
 4. Narcotics and dangerous drugs
 5. Alcoholism

H. Council on Social and Medical Services shall be concerned in the areas of:
 1. Health care facilities and services
 2. Emergency and disaster care
 3. Liaison with other health professional and health oriented organizations
 4. Relations with specialists not otherwise assigned
 5. Problems of aging
 6. Rural Health

Section 3. *Organization of Councils.*

A. Councils and the chairmen thereof shall be appointed by the Board of Trustees.

B. Each Council shall have authority to request the Board of Trustees to appoint subcommittees under the councils for any purpose within the functions of the Council. A member of the Council shall be designated as chairman of each subcommittee and shall

be selected by the Board of Trustees. Each subcommittee shall be used only for the specific purpose or purposes assigned to it and shall terminate as soon as its final report has been made or at the direction of the Board. The chairman of a Council may not serve as chairman of any subcommittee of the Council.

All Committees functioning under the Councils as of January 1, 1972, shall file a final report and be dissolved not later than June 30, 1972.

C. Members of the Illinois State Medical Society (who are not voting members of the Board of Trustees) may be appointed to serve as chairmen or members of any council or committee. Students nominated by Illinois Chapters of the Student American Medical Association, or other recognized student organizations approved by the Illinois State Medical Society Board of Trustees to serve with Illinois State Medical Society members on appropriate committees, may by action of the Board of Trustees, be accorded membership in this classification for the term of the committee appointment. Such members shall be permitted full privileges of committee membership, including (with the permission of the House of Delegates) the right to speak on the floor of the House, but to have no vote out of committee. Voting members of the Board of Trustees may serve as advisory members to any council or committee.

Recommendations for membership on any committee may be submitted to the Board of Trustees by the House of Delegates, or in writing by any member of the Society.

A state committee which reviews the decisions of a similar committee of a component socicty may not have as a member one who currently serves on the same committee of a component society or district.

D. Each Council shall submit for adoption a budget for the ensuing year which shall include any subcommittees, and the Board of Trustees shall determine the appropriation for each Council. Requests for additional funds must be approved by the Board before they are committed.

E. The president of the Society, the speaker of the House and the chairman of the Board shall be ex-officio members without vote of the various Councils, and may attend all committee meetings.

F. Terms of office of members of the Councils shall not be more than three years, but may be terminated at any time at the discretion of the Board. No member of a Council shall serve more than three consecutive terms. Service of two or more years in an unexpired term shall be considered a full term.

G. Vacancies on any Council or subcommittee thereof may be filled or membership therein may be enlarged or decreased by the Board of Trustees. The areas of concern of Councils may also be enlarged or decreased by the Board of Trustees.

H. The Chairman of a Council or subcommittee thereof, when he considers it expedient and with the consent of two-thirds of the members of the Council, may conduct business or hold meetings by mail or by conference call, provided all members of the Council are given opportunity to participate, that minutes of the transactions are recorded, approved by members participating, and circulated among all members.

I. Reports of subcommittees shall be made by the chairman to the Council under which they are operating.

Reports of Council activities shall include recommendations on reports and requests from subcommittees, and shall be made to the Board of Trustees by the chairman of the Council.

The chairman of any subcommittee may request the Board of Trustees to allow him, or any member of his subcommittee, to appear before the Board and to be heard.

All Councils shall submit to the House of Delegates, written reports summarizing all actions. Requests for House action or recommendations affecting Medical Society Policy must be submitted to the House in Resolution form.

Section 4. *House of Delegates Committees.* House of Delegates Committees of the Illinois State Medical Society shall be as follows:

A. Committee on Credentials shall consider all questions regarding the registration and credentials of the delegates. It shall distribute and receive the attendance slips for each session of the House of Delegates and perform any other duties assigned to it.

B. Committee on Rules and Order of Business shall consider all matters regarding rules governing action, method of procedure and order of business for the House of Delegates.

C. Committee on Tellers and Sergeants-at-Arms shall:
1. Serve the speaker of the House of Delegates.
2. Distribute, collect and tally votes when a ballot is taken, or a numerical tally is required.
3. Certify those in attendance in closed or executive sessions of the House of Delegates.

D. Committee on Changes in the Constitution and Bylaws shall consider all proposed amendments to the Constitution and Bylaws. The chairman of the Trustees Committee on Constitution and Bylaws, or his representative, shall serve in an advisory capacity to this reference committee and shall attend all sessions, including the executive sessions of the reference committee, to assist in the preparation of the report of the committee to the House of Delegates.

E. Ad hoc committees may be appointed by the speaker of the House of Delegates as the needs arise and any member of the Illinois State Medical Society may serve upon such committee. The number appointed to such committees shall be at the discretion of the speaker and the term of the committee shall be for such duration as is necessary to complete the task assigned but shall not exceed a duration of one year. Between meetings of the House of Delegates ad hoc committees shall report to the Board of Trustees, keeping it informed of all current activities.

F. Such other reference committees as the speaker shall deem necessary to conduct the business of the House, or consider the reports of officers, trustees, executive

administrator, the reports of committees pertaining to administrative activities, economics activities, scientific activities, public relations activities and legislative activities, as well as such resolutions, reports, and proposals as shall be brought before the House of Delegates.

Section 5. *Organization of House of Delegates Committees.*

A. Immediately after the organization of the House of Delegates at each annual or special meeting, the speaker shall announce the appointment from among the members of the House, of such committees as may be deemed expedient by the House of Delegates.

Each committee shall consist of five or more members unless otherwise provided, the chairman to be announced by the speaker. These committees shall serve during the meeting at which they are appointed.

B. References, resolutions, measures and propositions presented to the House of Delegates shall be referred to the appropriate committee, which shall report to the House of Delegates before final action shall be taken. A two-thirds affirmative vote of the House of Delegates shall be required to suspend this rule.

C. Each reference committee shall, as soon as possible after the adjournment of each session, or during the session if necessary, take up and consider such business as may have been referred to it, and shall report on same at the next session, or when called upon to do so.

Section 6. *Board of Trustees Committees.* The Board of trustees shall form the following committees within itself:

A. The Executive Committee shall consist of the president, the president-elect, the chairman of the Board, the chairman of the Finance and Medical Benevolence Committee, the chairman of the Policy Committee, the secretary-treasurer, the trustee-at-large and the immediate past chairman of the Board, provided he is still a Trustee.

The Board of Trustees may delegate to the executive committee any authority which it possesses and may authorize it to act in any given situation. In all matters of routine administration, special plans, policy, endorsement or expenditure it shall report to and request approval of the Board. It shall receive the reports of the Finance and Medical Benevolence Committee and Policy Committee and make recommendations concerning them to the Board. It shall furnish a report of its actions to the Board at each meeting.

B. The Finance and Medical Benevolence Committee shall consist of the Secretary-treasurer of the Society and three members of the Board appointed by the chairman. It shall develop for approval of the Board through the Executive Committee, a budget for the fiscal year. It shall supervise the financial transactions of the Society. It shall make recommendations to the Board for the control and investment of the funds of the Illinois State Medical Society.

This committee shall also:

1. Examine applications to the Society for assistance under the Medical Benevolence to determine eligibility for assistance;
2. Keep the names of the beneficiaries confidential and known only to the committee;
3. Recommend the allotment for each recipient; and
4. If funds available become inadequate to meet disbursements, request the Board of Trustees to appropriate sufficient funds to support the program until the next budget appropriation.

C. The Policy Committee shall consist of three mem bers of the Board appointed by the chairman. It shall continually review past and current proceedings of the House of Delegates to determine the established policies of the Illinois State Medical Society. It shall make recommendations for future policy by Board resolution to the House of Delegates.

D. The Ethical Relations Committee shall be constituted and function as stipulated in Chapter XI, Discipline, Part 2, Illinois State Medical Society procedures.

E. The Committee on Committees shall consist of three members of the Board appointed by the chairman. It shall serve to review the purposes, activities and structure of any councils or committees at the request of the Board. The committee shall recommend such changes in existing councils or committees as required to maintain the efficient operation of the affairs of the Society.

The activities and reports of the Committee on Committees shall be reviewed by the Executive Committee and approved by the Board of Trustees.

F. The Committee on Constitution and Bylaws shall consist of five members of the Board appointed by the chairman and it shall:

1. Receive from individual members, county societies, committees, the Board of Trustees, and the House of Delegates, all suggestions and proposals for modification of the Constitution and Bylaws;
2. Prepare for the consideration of the House of Delegates, all changes in the Constitution and Bylaws; and
3. Maintain constant surveillance of both documents to keep them current, effective and consistent with the policies of the House of Delegates.

G. The Committee on Publications shall be composed of five members of the Board of Trustees, and shall be responsible for the production of the *Illinois Medical Journal.*

It shall recommend to the Board of Trustees all policies governing the editorial, business and production aspects of the *Journal.* It shall supervise the editor in the selection and preparation of all copy, and it shall establish standards for the editorial content.

It shall establish advertising policies, rates, standards, and shall review all new accounts prior to acceptance, and shall approve reprint and circulation policies.

It shall conduct a periodic review of the printer's contract and solicit bids as indicated. It shall establish format, cover, type faces and general layout of the *Journal*.

It shall review, edit and supervise the publication of other materials as directed by the Board of Trustees.

H. The Advisory Committee to the Woman's Auxiliary shall consist of the president-elect as chairman, the president and the chairman of the Board of Trustees.

The committee shall provide advice and assistance to the president of the Woman's Auxiliary in her program for the year, and shall assist her in interpreting the activities of the Illinois State Medical Society.

I. The Board of Trustees may from time to time appoint such ad hoc committees as it may deem necessary but the duration of such committees shall be temporary and they shall function only for the specific purpose assigned and shall be terminated as soon as final reports have been made or at the direction of the Board. All ad hoc committees functioning under the Board of Trustees as of January 1, 1972, shall file a final report and be dissolved not later than June 30, 1972.

Section 7. *Powers of the Board of Trustees.* The Board of Trustees shall have power to increase or decrease the number of its committees, to change the area of concern of such committees, to enlarge or decrease membership and to fill vacancies thereon.

Section 8. *Term of membership.* The term of the members of the Board of Trustees Committees shall be for a duration of one year and they shall be selected by the Board annually immediately after the election of officers.

CHAPTER X. COUNTY SOCIETIES

Section 1. All county societies now in affiliation with this Society, or those which may hereafter be organized in this state, which have adopted principles of organization in harmony with this Constitution and Bylaws, shall upon application to and approval by the Board of Trustees, receive a charter from and thereby become a component part of this Society, and members thereof shall become members of this Society and the American Medical Association.

Section 2. Charters shall be issued only on approval of the Board, and shall be signed by the president and the secretary of this Society.

The Board shall have authority to revoke the charter of any component society whose actions are in conflict with the letter and spirit of this Constitution and Bylaws.

Section 3. Only one component medical society shall be chartered in any county.

Section 4. Every registered physician holding the title of Doctor of Medicine or its equivalent, who either (1) resides in the jurisdiction of a component society, or (2) resides in a state other than Illinois but practices principally in the jurisdiction of a component society and who is of good moral character and professional standing, shall be eligible to membership in that component society.

The component county society shall be the sole judge of the qualifications of its members, subject only to the stipulations contained in the Constitution and Bylaws.

Section 5. Any physician who has been disciplined by any action of a component society and believes he has not had a fair trial, shall have the right of appeal to the Board of Trustees.

Section 6. When a member in good standing in a component society changes his residence to another county in this state, such change of residence shall terminate his membership in such component society. (This ruling shall not apply to members in military service or in the service of the State or the United States government.)

Such member shall be entitled, upon his request, to a statement from his former secretary as to his standing. This statement of standing shall be issued without cost to the applicant.

He shall present this statement to the component society of the county to which he removes and it shall accompany his application for membership. The board of censors of the society receiving this application shall give this statement of prior standing due consideration before accepting or rejecting his application for membership.

Section 7. A physician living on or near a county line, or practicing partly or totally in an adjacent county, may hold his membership in the county most convenient for him, provided he submits written authorization to that society from the component society in whose jurisdiction he resides.

Section 8. The secretary of each component society shall keep a roster of its members, in which shall be shown the full name, address, college and date of graduation, date of license to practice in this state, and such other information as may be deemed necessary. In keeping such a roster the secretary shall note any changes in the personnel of the profession by death or by removal to or from the county. When requested, he shall furnish on blanks supplied him for the purpose, an official report containing such information for the secretary of this Society and likewise for the trustee of the district in which his county is situated.

Section 9. The secretary of each component society shall forward its roster of officers and members, and a list of delegates and alternate delegates to the secretary of this Society before the first Wednesday of January each year.

Section 10. Any component society which fails to pay its assessment or make the annual report required on or before March fifteenth shall be held as suspended and none of its members shall be permitted to participate in any of the business or proceedings of the Society or of the House of Delegates until such requirements have been met.

A member is in good standing unless otherwise disqualified, whose dues are paid on or before the first day of March of the current year. Immediately after the first of March, each delinquent member shall be notified that in consequence of nonpayment of dues, his membership is delinquent. If dues remain unpaid as of June thirtieth of the current year, membership shall be dropped automatically. The member may be reinstated by paying all delinquent dues, provided, in the interim, he has not been guilty of conduct prejudicial to membership; but if two or more years have elapsed since he was a member in good standing, he must in addition, make application as a new member.

Section 11. The Constitution and Bylaws of the Illinois State Medical Society and of the American Medical Association, together with the Principles of Medical Ethics of the American Medical Association, shall be binding upon the members of the component societies.

CHAPTER XI. DISCIPLINE

PART 1. COMPONENT SOCIETY PROCEDURE

Section 1. *Local Ethical Relations Committee.* Each component society may have, either by appointment or election, an Ethical Relations Committee, whose duty it shall be to prosecute formal charges of unethical conduct. In the event that the county society does not have such a committee, the district Ethical Relations Committee shall function in its behalf.

All parties may have legal counsel present to advise and counsel them during the proceedings, but such counsel may not participate in the proceedings, and may be excluded from the hearing by the chairman or by vote of the committee.

The component society Ethical Relations Committee may establish reasonable rules of procedure, and they shall not be bound by the technical rules of evidence as the same pertain in courts of law. In all proceedings before such Ethical Relations Committees, the complainant, the accused and all witnesses before the committee shall be placed under oath.

The Committee shall evaluate acts by the standards established by the House of Delegates of the American Medical Association (specifically known as the Principles of Medical Ethics of the American Medical Association), and by such additional standards as shall be incorporated in the Constitution and Bylaws of the Illinois State Medical Society and/or the county medical society.

Section 2. *Offenses.* Any member of a component society shall be subject to censure, suspension or expulsion by such component society when

A. He has been adjudged guilty by proper civil authorities of a criminal offense involving moral turpitude, or
B. He has been adjudged guilty by his component society in accordance with the procedural requirement of these bylaws:
 1. of a gross misconduct as a physician, or
 2. of a violation of the Constitution or Bylaws of his component society, or of the Illinois State Medical Society, or of the Principles of Medical Ethics promulgated from time to time by the American Medical Association.

Section 3. *Charges Initially Presented to the Illinois State Medical Society.* Original complaints received by the Illinois State Medical Society shall be referred directly to the secretary of the component society of which the accused is a member or to the district Ethical Relations Committee.

Section 4. *Principles of Justice.* The following principles of justice shall guide the Ethical Relations Committee in all disciplinary procedures.

A. An accused is presumed to be innocent until he has been proven guilty.
B. Formal charges before the Ethical Relations Committee of the component society or district Ethical Relations Committee must be presented under oath by the complaining party.
C. A trial shall be held by the committee within 30 days after the formal charges have been filed, unless continued by the chairman of the committee upon good cause shown.
D. The individual against whom formal charges have been filed shall be sent a copy of said charges by certified mail at least 10 days before the date set for the trial, together with a statement of the rights of the accused as follows:
 1. to be represented by any member of the society as counsel and that he may have legal counsel present;
 2. to cross-examine witnesses;
 3. to offer in evidence any pertinent records or documents:
 4. to object to any testimony or exhibits offered in evidence;
 5. to address the trial body in his own behalf;
 6. to be tried only on the specific charges filed;
 7. to have stricken from the record any improper testimony or exhibits;
 8. to appeal to the Board of Trustees of the Illinois State Medical Society.

Section 5. *Records.* A comprehensive stenographic record of the proceedings, together with all exhibits, must be kept for reference, and shall be available until final adjudication has been made

In the event of an appeal being taken from the verdict of the local or district Ethical Relations Committee, the stenographic record shall be forwarded by certified mail to the Board of Trustees of the ISMS at least ten days prior to the date the appeal is to be heard.

If the component society fails to provide the record on appeal, the Ethical Relations Committee of Illinois State Medical Society shall find the accused not guilty.

Section 6. *Verdict.* The committee, sitting as a trial body, shall find the accused either guilty or not guilty. If the verdict is guilty, the trial body shall recommend censure, suspension or expulsion.

The findings of the trial body must be presented to the component county society for approval or rejection. The accused must be notified by certified mail at least ten days before the date set for the meeting at which this action will be taken. If the findings of the trial body are against the accused the secretary of the component society shall acquaint the accused, by certified mail, with his right of appeal within thirty days to the Board of Trustees of the Illinois State Medical Society.

PART 2. ILLINOIS STATE MEDICAL SOCIETY PROCEDURES

Section 1. *Illinois State Medical Society Ethical Relations Committee.* The Board of Trustees shall appoint from its members, an Ethical Relations Committee to review decisions of the component society involving the interpretation of the Principles of Medical Ethics, violations of the Constitution and Bylaws of the Illinois State Medical Society or its component societies, and charges of misconduct of members of the Society.

Section 2. *Appeals from Component Society Verdicts.* Appeals received by the Illinois State Medical Society Board of Trustees shall be referred to the Ethical Relations Committee of the Board for review. (Appeals must

be accompanied by a comprehensive stenographic record of the proceedings taken before the component county society together with all exhibits submitted in evidence. If the component county society fails to provide the record on appeal, the Ethical Relations Committee of the Illinois State Medical Society shall find the accused "not guilty"). The committee shall notify the accused and the secretary of the component society by certified mail at least thirty days prior to the date set for the hearing of the appeal. The chairman of the committee shall preside over the hearing in accordance with the rules established by the Board of Trustees.

Section 3. *Verdict.* The Ethical Relations Committee of the Board of Trustees shall hear any new and pertinent evidence any interested party desires to present, and at the conclusion of the trial the decision of the component society shall be affirmed, overruled or sent back to the component society for reconsideration.

Section 4. *Notification and right of appeal.* The secretary of the Society shall notify the defendant and the secretary of the component society wherein the defendant holds membership, of the action of the Board. In the event of a decision against the accused he shall have the right to appeal the decision to the Judicial Council of the American Medical Association and the secretary of the State Society shall so notify the accused of this right.

CHAPTER XII. PEER REVIEW

PART 1. COMPONENT SOCIETY PROCEDURE

Section 1. *Local Peer Review Committee.* Each component Society shall have, either by appointment or election, a Peer Review Committee whose duties it shall be to review all proper complaints and inquiries brought before it by physicians, patients, institutions, insurance carriers, or government agencies.

The district peer review committee shall function and operate on behalf of any county society which does not establish such a committee.

Section 2. The committee shall consist of a chairman and such members representing both general practice and various specialties as each individual county society shall determine. Such committee should have access to counsel from each of the various medical specialties. The component county society may establish reasonable rules of procedure but shall not be bound by the technical rules of evidence as the same pertains in courts of law. All proper complaints shall be reduced to writing and shall be signed by the individual making the complaint.

Section 3. Original complaints received by the Illinois State Medical Society shall be referred to the proper county society or to the district committee.

Section 4. The Peer Review Committee shall include the functions of the grievance committee, the prepayment plans and organizations committee, the mediation committee and any other committee having to do with investigations and review but shall not replace or supersede the ethical relations committee.

Section 5. The Peer Review Committee shall initiate consideration of all complaints and matters filed with it within 60 days from the date of filing and shall render an opinion within 30 days after the conclusion of the hearing. In the event the committee does not follow this procedure any party may appeal for relief to the proper district committee whose procedure shall be the same as is set forth herein for county societies.

Section 6. The Peer Review Committee shall have no disciplinary powers but instead, shall report its findings in writing to all parties involved. In the event the investigation and study of the committee results in a determination that there has been a violation of law or unethical conduct on the part of any physician, or a violation of the Constitution or Bylaws of his component society; or of the Illinois State Medical Society, or of the Principles of Medical Ethics promulgated from time to time by the American Medical Association, the matter shall be referred in writing to the component society.

Section 7. In its study and deliberations the Peer Review Committee shall evaluate acts by the standards established by the House of Delegates of the American Medical Association (specifically known as the Principles of Medical Ethics of the American Medical Association), and by such additional standards as shall be incorporated in the Constitution and Bylaws of the Illinois State Medical Society and/or the county medical society.

Section 8. Any party to the proceedings considering himself aggrieved by the findings and recommendations of the committee shall have the right to appeal through the component society to the Illinois State Medical Society.

Section 9. In the event of an appeal to the Illinois State Medical Society, the county society shall send to the Illinois State Medical Society a copy of the complaint, the exhibits and the opinions of the county or district committee. Any appeal hereunder shall be filed with Illinois State Medical Society within 30 days after the final opinion of the county or district committee has been rendered.

PART 2. ILLINOIS STATE MEDICAL SOCIETY PROCEDURES

Section 1. All appeals received by the Illinois State Medical Society shall be referred to the Council on Economics and Peer Review of the Board of Trustees, which shall review opinions of the county or district peer review committee. The Council shall have the power to counsel with and obtain information from medical specialists when appropriate.

Section 2. The Council upon receiving notice of an appeal shall set the matter for hearing within 30 days after the appeal has been filed and at such hearing shall review the record sent to it from the county society or district society, receive additional pertinent evidence any interested party desires to offer and render its conclusions and findings in writing, copies of which shall be mailed to all interested parties. The Peer Review Committee shall have no disciplinary powers but instead, shall report its findings to all parties involved. The conclusions and findings shall be advisory only.

Section 3. The Council on Economics and Peer Review of the Illinois State Medical Society shall include the functions of the grievance committee, the prepayment plans and organizations committee, the mediation committee and any other committee having to do with investigations and review but shall not replace or supersede the ethical relations committee.

Section 4. In the event the investigation and study of the Council results in a determination that there has been a violation of law or unethical conduct on the part of any physician, or a violation of the Constitution or Bylaws of his component society, or of the Illinois State Medical Society, or of the Principles of Medical Ethics promulgated from time to time by the American Medical

Association, the matter shall be referred in writing back to the component society.

CHAPTER XIII. MISCELLANEOUS

Section 1. The fiscal year of this Society shall be from January 1 to December 31 inclusive.

CHAPTER XIV. AMENDMENTS

The House of Delegates may amend any article of these Bylaws by a two-thirds vote of the delegates present at any meeting, provided that such amendment shall not be acted upon before the day following that on which it was introduced.

Index to Constitution and Bylaws

Ad hoc Committees 310
Advisory Committee to Woman's Auxiliary 312
Amendments
- to the Bylaws 315
- to the Constitution 304

American Medical Association
- election of Illinois Delegates, alternates 307
- membership 304

Annual Dues 305
Audit and Financial Statement 308

Benevalence Fund 308
Baard of Trustees
- committees 311
- election by House of Delegates 312
- election of Chairman 308
- duties 307
- meetings 308
- powers 312
- quorum 308
- term of office 312
- vacancies 308

Bonding of officers and emplayees 308
Bylaws 304

Changes on Constitution and Bylaws Committee 310
Committee on Committees 311
Component Societies 304
Composition of the Society 304
Constitution and Bylows, Committee on 310
Conventions and Meetings 304
- Education and Scientific Programs 306
- House of Delegates 306

Councils (standing committees)
- duties 309
- organization of 309
- reports 310
- terms of office 310
- vacancies 310

County Societies 308
- Organization of 312

Credentials Committee 310

Discipline
- Companent Saciety Procedure 313
- State Medical Society Procedure 313

District Committees 308

Economics and Peer Review, Council on 309
Education and Manpawer, Council on 309

Educational and Scientific Programs 306
- date of 306
- meeting place 306

Enviranmental and Community Health, Council on 309
Ethical Relations Committee 311
Executive Administrotor 308
Executive Committee 311

Finance ond Medical Benevolence Committee 311

Governmentol Affairs, Council on 309

House of Delegates
- composition 306
- delegates 306
- district divisions 306
- elections 307
- meetings 306
- order of procedure 306
- term of office 307

House of Delegates Committees 310
- duties 311

Membership
- associate members 305
- discrimination of membership 305
- distinguished members 305
- emeritus members 305
- in-training members 305
- provisional members 304
- regular members 304
- retired members 305
- service members 305
- student members 305
- tenure and termination of membership 305

Officers
- elections 306
- duties 307
- terms of affice 307

Medical-Legal, Council on 309
Mental Health and Addiction, Council on 309
Miscellaneous 315

Peer Review
- Component Society Procedure 314
- State Medical Society Procedure 314

Policy Committee 311
Publication Committee 311
Public Relations and Membership Services, Council on 309
Reference Committees 310
Rules and Order of Business Committee 310
Seal, the 304
Social and Medical Services, Council on 309

Tellers and Sergeants-at-arms Committee 310

1972-1973 Policy Manual of the Illinois State Medical Society

"Policy statements shall be defined as guidelines for the management of the Illinois State Medical Society affairs, based upon prudence, sound judgment and experience."

"Rules and regulations may be prepared by the Board of Trustees or by committees, for use in the implementation of policy."

This manual shall be a guide for officers, trustees, committee chairmen and headquarters staff to the stand taken by the House of Delegates to the Illinois State Medical Society on all issues involving Society policy.

Its statements shall combine and reconcile the best expressions made on all phases of policy involving the House of Delegates, the Board of Trustees and the various committees.

All policy statements (except those involving the funds of the Society) shall have the approval of the House of Delegates, since the Constitution and Bylaws provide in ARTICLE V:

"The House of Delegates shall set the basic policy and philosophy of the Society."

All policy statements developed during the interval between meetings of the House shall be submitted at its next meeting for action. The House may:

(1) approve, amend, or reject—

(2) refer the statement to the Board for reconsideration and subsequent report—

(3) remand the statement to the committee from which it came for further study and report.

Policy statements for the consideration of the House may appear as a portion of the annual report of the Policy Committee, or they may be contained in other reports to the House. The final statements for publication in this Policy Manual are to be prepared by the Policy Committee. Any member of the Illinois State Medical Society may submit a policy statement for consideration.

Temporary policy between meetings of the House is determined by the Board. Committees may request Board consideration at any time.

The Illinois State Medical Society shall support policy statements approved by the House of Delegates of the American Medical Association.

National policy is the prerogative of the national association. Until specific contrary action emanates from the AMA House of Delegates, the Board of Trustees and the officers of the ISMS shall consider all such policy as binding.

Policy action at the state level does not rescind official AMA rulings in Illinois, and the Society must recognize such policy and until it has been changed at the national level.

The same "chain of command" should exist between the county medical society and the ISMS House of Delegates. Policy established at the State Society level must prevail until majority action by the House of Delegates has rescinded or reversed the statements. This represents "majority rule" and must be followed closely to preserve the democratic processes.

Abortion

The Illinois State Medical Society is opposed to induced abortion except when under the following conditions:

1. There exists documentation of a severe threat to the health or life of the mother, or

2. There is documented medical evidence that the conceptus may be born with incapacitating physical or mental abnormality, or

3. There is documented evidence that continuation of a pregnancy resulting from statutory or forcible rape or incest may constitute a threat to the mental or physical health of the patient, and

4. Two other physicians chosen because of their recognized professional competence have examined the patient and concurred in writing, and

5. The procedure is performed in a hospital legally licensed and approved by the State of Illinois for the care of maternity patients.

Alcoholism

Since alcoholism has been widely regarded as a disease for some time and because it is impossible to differentiate immediately between a chronic alcoholic and any other intoxicated person, the individual who is acutely ill from alcohol ingestion should be considered a health problem and therefore be adjudicated within the purview of the medical and other health professions.

AMA-ERF

The Illinois State Medical Society's dues billing form shall include the names of all medical schools in Illinois so that every member may designate which school is to receive his AMA-ERF contribution.

Ambulance Services

All ambulance services should meet minimum standards as developed from time to time by the Illinois State Medical Society and the State of Illinois.

Assessments

Compulsory assessments of members of hospital staffs for any purpose are unethical and improper.

Athletic Programs

Children of school age, through the 9th grade, should not participate in body contact sports.

Elementary school children develop better physically if activities are informal and not highly competitive.

Medical supervision of all athletic programs is essential.

Audits & Surveys (Hospital, nursing homes, etc.)

Audits and surveys which impinge on personal privacy, patient care and local hospital trustee and medical decisions as to management should not be condoned.

Autonomy of County Medical Societies

No ruling of any county medical society shall conflict with the Principles of Medical Ethics of the American Medical Association, or with the Constitution and Bylaws of the Illinois State Medical Society.

In all other areas, the county society shall be autonomous.

Birth Certificates

Birth certificates should contain only such items as are pertinent to their function. Information recorded on birth certificates should not be provided to organizations or individuals for other than approved purposes.

Birth Control

The preventive medicine approach to the problem of unwanted pregnancies should be encouraged through family life education in the schools, wider dissemination of family planning information, including birth control information and devices, and encouragement of research in population control methods.

Blood Procurement

Inasmuch as blood procurement affects the entire community, any blood procurement program should be carried out only with the approval of the local county medical society involved.

Budgets—(see "Financial Policies)" Committee Appointments

The chairman of the Board of Trustees and the officers of ISMS shall give the trustees an opportunity to recommend physicians from their districts for appointment to various committees. Trustees shall receive the proposed list of committee appointments for their consideration and review prior to the meeting of the Board at which the final committee personnel is to be approved.

Elective committees should serve for uniform terms of office—preferably three years. These terms of office should be held on a staggered basis to provide continuity in the committee structure. Individual tenure on any committee should be limited to a maximum of nine years of continuous membership—whether elected or appointed.

Physicians appointed to an Illinois State Medical Society committee must be members in good standing of this Society.

Communicable Diseases

Physicians, especially those engaged in public health work, should enlighten the public concerning all regulations and measures for the prevention and control of communicable diseases. When an epidemic prevails, a physician shall continue his labors without regard to his own health.

Community Health Week

The medical profession shall provide the scientific leadership to focus attention on the health needs of the community and to encourage and assist in developing Community Health Week activities during the winter or spring of the year.

Comprehensive Health Planning

Upgrading of local health facilities should be implemented through Comprehensive Health Planning on a home rule basis rather than through metropolitan- oriented advisory services.

Conflict of Interest

When a case of conflict of interest arises and is self-evident, by the attitude shown by the individual concerned, it should be referred to the Executive Committee of the Board of Trustees of the ISMS for consideration.

Constitution and Bylaws

Final copy of any changes made by the House of Delegates in the Constitution and/or the Bylaws shall be prepared for publication by the Committee on Constitution and Bylaws, in consultation with legal counsel, making sure that the published changes reflect the thinking expressed by the action of the House.

Continuing Education

Continuing education shall be one of the basic purposes of the Illinois State Medical Society for scientific advancement, humanization of medicine, improvement of medical public relations, and development of cooperation and rapport with the public. The Society should join with other interested parties in developing a multi-organizational approach to continuing medical education and all members should be encouraged to participate in the AMA Physician Recognition Award.

Co-operation with the American Medical Association

Actions of the AMA House of Delegates are binding upon its membership at all levels, county, state and national.

The Illinois State Medical Society reaffirms the position on the categories of ISMS membership as they relate to membership in the American Medical Association.

(Since all members of the Illinois State Medical Society are also members of the American Medical Association, this is universally true in Illinois. The right to disagree, the right to protest, the right to become "the loyal opposition" is not questioned. However, until such time as the AMA House has reversed its decision, it is mandatory that the membership abide by the will of the majority.)

Cultists, Association with

The Judicial Council of the American Medical Association has ruled that it is unethical to associate VOLUNTARILY with an individual who practices as a member of a "cult."

Disaster Control

Any disaster creates an obvious need for trained personnel to aid the sick and injured. Local medical societies should cooperate to provide medical self-help programs. County societies should provide training for their membership in the treatment of mass casualties, radiological casualties and in the organization, operation and maintenance of emergency hospitals.

Discrimination—(see "Freedom of Choice")

Drugs, Prescriptions

Substitution of prescribed drugs by pharmacists is opposed, except in cases of extreme emergency, unless there be full explanation and agreement by both the patient and the doctor.

Dues, Recommendation of the Board to the House

The chairman of the Board of Trustees shall place the question of dues for the coming year on the agenda for consideration at the spring meeting of the Board.

Immediately following this meeting, written notice of the recommendation regarding dues for the next fiscal year, shall be mailed to all delegates and alternate delegates from the component societies, and also to all presidents and secretaries of county medical societies. This recommendation shall also be published in the *Illinois Medical Journal* as a part of the annual report of the Chairman of the Board.

Education, Primary and Secondary

Primary and secondary education is a community problem. In order to retain jurisdiction of these grade schools, finances should be raised by taxation at the local level.

Ethics

Cases involving ethics shall reach the state society level only by means of an appeal. As outlined in the Bylaws, the state society committee shall serve only as an appellate body to review such cases.

Examinations

All physical examinations should be performed in the physician's office. No examinations should be conducted on a group basis unless authorization has been given by the local county medical society in a single instance or for a specific purpose.

This general statement does not apply to the industrial or occupational health physican in his in-patient activities.

Facility Medical Boards (Physicians)

In all legislation which establishes boards for the administration of medical facilities operated by governmental units, at least one-third of the board should be physicians licensed to practice medicine in all its branches.

Federal Funds

When a federal government assistance program is essential it should be conducted under the administration and control of local government. The Society does not favor any federal assistance program which removes administrative control from the state or local level.

Fee Schedules

No member or committee shall be permitted to approve a fee schedule for the Illinois State Medical Society until it has been submitted to and approved by the House of Delegates or the Board of Trustees.

Individuals covered by various fee schedules shall receive the best type medical care in all cases, and the physicians involved shall be remunerated according to the accepted fee schedule. Fees should be commensurate with services rendered.

Financial Policies (also see "Assessments," etc.)

(1) The Finance Committee is to make budgetary recommendations to the Board of Trustees; however, such recommendations must be approved by the Board.

(2) The expenses of any duly elected delegate or alternate delegate attending the meetings of the House of Delegates of the American Medical Association shall not be assumed by the ISMS until he enters his official term of office set by the Constitution and Bylaws of the AMA.

(3) The expenses of any official representative of the ISMS attending any authorized meeting shall be determined by the Finance Committee and approved by the Board of Trustees.

(4) Any new project authorized by House action requiring the expenditure of funds must be accompanied by an estimate of the cost and suggested methods of providing the necessary funds.

(5) Budgets submitted to the House by the Board should provide for the ensuing fiscal year.

(6) In addition to fixed reserves, the development of a contingency reserve is desirable.

(7) All financial records shall be available at headquarters office, and may be examined by any member of the Society. A semi-annual summary of the financial statements of the Society shall be mailed to any county society secretary or delegate if requested. A projected budget for the next fiscal year shall be mailed to the members of the House of Delegates at least 30 days prior to the annual convention. These reports shall be in the format customarily used in ordinary corporate practice.

Freedom of Choice

The mutual right of physicians and patients to exercise freedom of choice in medical matters shall be maintained. This includes the right of the patient to choose the physician by whom he will be served, and the right of the physician (except in emergencies) to a corresponding freedom of choice. All members of the Illinois State Medical Society enjoy the same rights and privileges and are bound by the same obligations and standards of professional conduct.

Foundations for Medical Care

The Illinois Foundation for Medical Care is a not-for-profit corporation established to provide physicians with leadership roles in modifying health care delivery in their communities, thus assuring quality care at reasonable cost. Establishment of autonomous county and/or multi-county foundations under the sponsorship of local medical societies is encouraged and, together, local and state foundations shall provide a mechanism through which foundation-sponsored programs can be developed and administered throughout the state.

Health Care—Ancillary Services

All segments of our population are entitled to and shall receive the best health care available. The physicians in Illinois are encouraged to cooperate in the implementation of any national program meeting with the general policy statements of the Society. (This shall be interpreted to include health aspects in nursing home care, use of recreational facilities, environmental health, public health, employment problems, etc., and any other area which involves the health of the residents of this State.)

Health Care Costs

The public should be educated concerning the difference between "health care costs" and "medical care costs." Members of the profession should cooperate with the various ancillary groups and should be able to explain the cost factors involved in total care.

Health Careers

All capable and worthy individuals interested in medicine as a career shall be encouraged and assisted by the Illinois State Medical Society. Those interested in paramedical fields shall be provided with all pertinent information.

Hospitals

Physicians should sponsor and assist in the development of all medical staff committees within the hospital.

The local medical profession should cooperate to achieve the accreditation of all eligible hospitals, and should encourage the stabilization or reduction of hospital costs in all areas where they have authority.

Hospital Assessments—See Assessments

Hospital Committees (Dealing with physician-patient relationship)

All committees dealing with the review of physician-patient relationship in hospitals and nursing homes are urged not to release findings to any third parties except by subpoena or court order. Any reports issued by the committees involved should be submitted to the chief of staff for his disposition.

Hospital-Medical Staff-Management Relationship

Any proposal or arrangement between institutional management and medical staffs should not conflict with the Principles of Medical Ethics or abridge the property right endowed upon the individual physicians by the Illinois Department of Registration and Education.

Hospital Records and Their Availability

Hospital records are privileged information and the property of the patient, kept in trust by the hospital. They are not to be released except on a court order.

Upon receipt of a request signed by the patient, an abstract or a summary shall be provided when needed, to insurance companies, governmental agencies, consulting physicians, etc.

Hospital Staff Privileges

The medical staff of a hospital does not have the privilege or the right to make compulsory assessments of members of the medical staff for building funds, or to demand an audit of staff members' personal financial records as a requisite for staff appointments.

House of Delegates, Special Meetings of

When a special meeting of the House of Delegates is scheduled which may involve an increase in dues or a special assessment, the call for that meeting shall contain specific notification of that possibility.

Immunization Program

Illinois residents should be provided all types of immunization. Physicians are requested to provide this protection especially to all children, or to encourage the local public health agency to perform this function.

Every school should have a school health committee with at least one physician as a member. County advisory school health councils should assist in coordination.

Impartial Medical Testimony

The ends of justice are served when impartial medical witnesses are available to give testimony. The ISMS supports this concept and offers its assistance in the provision of impartial medical testimony.

Indigent, The Care of the

Personal medical care is primarily the responsibility of the individual. When he is unable to provide this care for himself, the responsibility should properly pass to his family, the community, the county, the state, and only when all these fail, to the federal government, and only in conjunction with the other levels of government in the order above.

The determination of medical needs should be made by a physician. The determination of eligibility should be made at the local level with local administration and control. The principle of freedom of choice should be preserved.

Individual Rights

Since this Society believes that a strong America is a free America, the rights of an individual, or a group of individuals, to openly express themselves cannot be condemned even if one is in complete disagreement, if the laws of the land are not violated. To support such condemnation would be inconsistent with this Society's basic philosophy.

Insurance Plans

Physicians are urged to cooperate with voluntary health insurance plans approved by the Illinois State Medical Society.

Fixed fee schedules should not be accepted. All fees should be based upon the usual and customary fee concept.

Insurance programs for the membership of the Illinois State Medical Society should be studied and implemented by the proper committee. Major medical and comprehensive hospital group coverage should be part of this insurance package.

Journal Publication

The Publications (Journal) Committee, with the approval of the Board of Trustees, has authority over the publication policy and the screening of all advertisers and advertising copy appearing in the *Illinois Medical Journal.*

Laboratories

All laboratories providing medical data should be under the direct supervision of a physician.

Lay Employees' Functions

Policy is established by the House of Delegates.

Staff shall cooperate with officers and committee chairmen in setting up activities and in carrying out all necessary routine.

Staff also shall keep new officers and committee chairmen aware of policy statements, and assist them in the preparation of reports to the House of Delegates to:

change existing policy

establish new policy

request House approval of committee projects and/or procedure involving policy.

Committees shall be informed of their right to set up operating rules and regulations.

Legal Counsel

The legal counsel of the Illinois State Medical Society shall concern himself with official inquiries from officers, trustees, committee chairmen and county medical societies. Such inquiries shall be channeled through the Executive Administrator.

Legislation

All matters pertaining to state or federal legislation shall be referred to the Governmental Affairs Council for consideration and recommendation prior to Board of Trustees and/or House of Delegates action.

Matters pertaining to federal legislation shall be checked against recommendations or policies of the American Medical Association by the Council on Governmental Affairs of the Illinois State Medical Society prior to making a recommendation either to the Board of Trustees or to the House of Delegates.

Before any legislation is developed for presentation to the Illinois General Assembly, the proposed law shall be considered by the Council on Governmental Affairs which shall work in close cooperation with any other Society committee involved. The instigating committee should determine the content of the law and the Governmental Affairs Council primarily should consider relationship of the proposed legislation to the total legislative program.

Any Council or Committee recommending legislation to the attention of the Governmental Affairs Council must provide expert witnesses when called upon to testify before Senate and House Committees in support of, or in opposition to, the legislation recommended by the Council or Committee.

Mailing List

The use of the mailing list of ISMS members must be approved by special action of the Board of Trustees.

Medical Care, Provision of

Medical care shall be provided regardless of the ability of the patient to pay. Physicians shall not refuse to render needed emergency care to any patient.

Medical Education

The Illinois State Medical Society supports development of innovative curricular and co-curricular programs in medical education maintaining a firm foundation in the basic sciences.

Medical Examiners

ISMS favors a medical examiner system throughout the state in preference to a coronor system, wherever practical.

Medical Representation in Government Planning

In health programs financed by government funding in an Illinois community, there shall be representation at the highest policy level by an official representative of the State Society and the appropriate county medical society involved. Remuneration for services in above programs shall follow the policies of the Illinois State Medical Society.

Only those programs which have involved physicians at the local level in the planning and development stages shall be approved by ISMS.

Membership in Paramedical and Service Organizations

Membership in Chambers of Commerce (city, state and national) is to be encouraged. This policy extends to the individual physician as well as to the component societies.

Membership in the Illinois Association of the Professions is encouraged. Medicine should be well represented among these allied professional groups and the growth and development of the Association is of concern to ISMS economically, politically and scientifically.

The Society recommends that physicians affiliate with service clubs, local political action groups and participate to the fullest extent possible in affairs affecting the health and welfare of the residents of Illinois.

Membership of Osteopathic Physicians in ISMS

Osteopathic physicians who meet all qualifications for membership, base their practice on the same scientific principles as those adhered to by members of the AMA, and are licensed to practice medicine in all its branches in Illinois, may be accepted as active members by the county medical societies throughout the state, and be accorded all privileges of full membership at the county and state levels and be so reported to the American Medical Association for acceptance at that level.

Mental Health

Mental health planning should be implemented at the community level. County medical societies should be kept aware of their responsibilities to assist in developing improved mental health facilities.

A physician licensed to practice medicine in all its branches should be required to certify the discharge of any patient from a psychiatric institution.

Multiphasic Screening

Automated multiphasic health testing and screening laboratories are recognized as an extension of services available to the physician for the health needs of individual patients. A position statement on multiphasic health testing, developed by the ISMS Council on Environmental and Community Health, and the American Medical Association Guidelines for establishing and operating such programs are attached as an appendix to the Policy Manual.

Nurses—Shortage

A severe shortage of graduate nurses continues to imperil the provision of quality patient care. The ISMS supports all forms of qualified nursing education and urges that all such schools be encouraged to remain in operation.

Nutrition

Prophylactic use of iron fortified foods is approved in accordance with a 7-point statement developed by the Nutrition Committee and the Council on Environmental and Community Health in 1971.

Occupational Health

Occupational health is an essential ingredient of employee welfare. The adoption and development of health programs in industry should be encouraged.

Occupational health will be advanced through the utilization of all physicians involved in industrial work.

Osteopaths, Association with

Voluntary professional associations with a Doctor of Osteopathy are not deemed unethical if the Doctor of Osteopathy bases his practice on the same scientific principles as those adhered to by members of the American Medical Association and if he is licensed to practice medicine and surgery in all of its branches in Illinois.

Placement Service

Before the Physicians' Placement Service recommends that a town in Illinois be listed as needing a physician, it shall be established that the need actually exists; that the community can support a physician; that certain physicial assets (office—home—schools, etc.) are available for the physician and his family.

The qualifications of the physician also shall be ascertained prior to furnishing him with the list of available areas in Illinois needing a physician.

Policy Statements

Policy statements shall be defined as guide lines for the management of the Illinois State Medical Society affairs, based upon prudence, sound judgment and experience.

Rules and regulations may be prepared by the Board of Trustees or by committees, for use in the implementation of policy.

Polls, Opinion

The vote of the House of Delegates shall express the opinion of the majority of the Illinois State Medical Society membership. Since delegates are the duly elected representatives of their county medical societies and their voting reflects the thinking of their constituents, a majority opinion has been expressed, and a membership poll becomes unnecessary except under very exceptional conditions.

Prepayment Plans and Organizations

It is not within the province of ISMS to act in other than an advisory capacity when working with a "third party plan," and its best efforts should be directed toward supplying guidance, education and communications between the membership and the prepayment plans and organizations involved.

The principle of free enterprise as exemplified by private insurance companies and the "Blue" plans is to be endorsed.

Such plans should recognize that free standing medical and surgical facilities are acceptable methods of delivering high quality health care. Reimbursement for expenses incurred as an outpatient in such facilities should be included in the benefits of these plans.

Press

All county medical societies should cooperate with the local press. The public should be provided with prompt and accurate information in all health fields; the source of this information should be the medical profession.

County medical societies should provide information at the local level; the State Society is responsible for press releases involving State Society officers or any official statements of the Society appearing in the press.

A code of ethics applicable to medicine and the fourth estate should be developed. (That used in the Decatur area has been given national recognition by the AMA.)

Publication of Research Data

In releasing research material for publication in the *Illinois Medical Journal,* or any other media, extreme care should be exercised. The welfare and privacy of the patient, the professional reputation of the physician should be of primary concern.

If any question arises, consultation with the Board of Trustees is suggested. All such inquiries should be addressed to its chairman.

Public Affairs

No officer or member of the Board of Trustees should be permitted (during his term of office) to allow his name as an officer or a member of the Board to be used in lists endorsing candidates for public office. Naturally his right to this privilege as a private individual is not affected.

Public Aid

The "chain of command and procedure" in handling problems arising in the field of public aid shall be from the county to the state advisory committee; then the state advisory committee shall assume the responsibility of making the medical program work and cooperating with the Illinois Department of Public Aid to maintain the best type medical care for the recipients of state aid.

The fees paid by the state/federal programs to physicians shall be based upon the usual and customary fee concept.

An extensive program of education should be conducted for the recipients of public aid. This should include the intelligent handling of all monies provided.

Rehabilitation of all recipients should be of paramount concern.

Public Health Departments

Public Health is the art and science of maintaining, protecting and improving the health of the people through organized community efforts, including contributions by voluntary health associations, medical societies and other health-oriented groups.

Full-time modern local Health Departments adequately financed and staffed at the county or multiple county level are highly desirable and if available, would be capable of providing these services to the people throughout the state. It is of paramount importance that such departments should be established where none now exist and that county medical societies, as well as physicians, should give their wholehearted support.

Public Safety

Motor vehicle operators should be licensed on the basis of the applicant's physical and mental capacity to operate such a vehicle safely.

Rebates

In conformity with the AMA Principles of Ethics, rebates of any nature to any member, county or regional medical society, are unethical." This statement on rebates was developed as a result of a letter regarding collection services. It read in part:

"It is our policy to remit to a participating association the sum of 10 per cent of the gross book sales to its members in addition to 10 per cent of the gross commissions received from collections. A report and accompanying payment is submitted monthly from our office."

Reference Committee Appointments

Whenever possible at least two members shall be retained on all reference committees for the following year in order to effect continuity of experience.

Reference Service

Physician reference service shall be the responsibility of the county medical society. When any such request is received at the state society office or by any officer of the ISMS, it shall immediately be referred to the secretary of the county medical society involved.

Rehabilitation

All physical rehabilitation activities should be prescribed by a physician and the treatment carried out under the supervision of a physician.

Medical societies should render assistance to public and private agencies regarding rehabilitation facilities to be used and in the selection of patients for these services

Insurance carriers should be encouraged to include rehabilitation services in their contracts.

Relative Value

The Relative Value Study is not a fee schedule and is to be used for information only.

No co-efficient shall be established at the state level. The data contained in the study may be used by the ISMS, its committees or by any county medical society.

The study should be revised at appropriate intervals upon the recommendation of the committee with the approval of the Board of Trustees.

Upon request, copies may be furnished third party purveyors of health care services.

Specialty Society Representation on ISMS Councils

For the improvement of communication and the discussion of problems of mutual interest and concern, closer liaison between specialty societies of medicine and the councils of the Board of Trustees is desirable. Representatives to serve in this capacity may be nominated by the specialty society, approved by the Board of Trustees of ISMS, and designated as consultants to the council without vote, in compliance with the Bylaws.

Stationery, Use of Official

No officer, trustee, committee chairman or staff director is to use the official stationery of the Illinois State Medical Society for personal statements of any nature. This shall pertain especially to the endorsement of any candidate for public office.

Surveys

The Illinois State Medical Society endorses the principle of mass surveys and encourages the use of this method whenever it meets with the approval of the local county medical society.

Any new state program involving more than one county society should be submitted to the Board of Trustees for initial approval.

Veterans Administration

It is our belief that a Veterans Administration hospital should admit only those patients with service-connected disabilities, except in those instances where the veteran is financially unable to pay for his medical care and hospital services, as shown by a means test.

Woman's Auxiliary

Projects in which the Auxiliary participates shall be approved by the local county medical society.

Requests for cooperation between the Auxiliary and the Illinois State Medical Society should be channeled through the Advisory Committee provided by the Board of Trustees.

APPENDIX

Multiphasic Health Testing Council on Environmental and Community Health Statement

During the recent past there has been an upwelling of various automated or multiphasic health testing or screening programs. The use of the results of such testing has at times led to a false sense of security on the part of patients, whereas other programs are being foisted on the public with the view to making money with very little concern for an individual's well being. Other programs are offered as having direct, immediate and practical medical value, without review by a physician. These many concerns prompt the necessity of a position statement on the use and application of such programs.

There is a place for computer and automated multiphasic testing and screening programs as an extension of the services available to the physician as he considers each individual case. It is entirely possible that such a mechanism will enable a physician to expand his scope of operation.

Forms of automated multiphasic health testing have been used by public health agencies and centers for developmental research in epidemiology. In these programs, asymptomic control patients have been tested. Testings have been done to establish medical priorities or case findings in communities. Other testing has been done to separate those who probably have certain characteristics from those who do not.

Occupational or industrial health programs have used testing programs for the betterment of employees' health and working conditions. Programs such as these, whether a pre-employment examination or a study to control health hazards, are not necessarily related to medical care as such. The physician in charge may or may not at the same time be the attending physician of the employee.

As far as automated multiphasic health testing programs for individuals are concerned, these programs obtain health-related data and act as data collecting sources, following a routine using technicians or mechanical and electronic devices to determine facts. In several hours a variety of tests and measurements can be made which may provide a profile of an individual's physical status. Such a profile can be of value to a physician. The testing is not diagnosis or interpretation.

Some individually oriented automated multiphasic health testing programs are operated commercially on a for-profit basis. Many of these do determine and report facts accurately. Some, however, give the appearance of encouraging individuals to be tested without a medical referral for the tests. Some indicate that when the results are compared against standards or norms the individual does not even have to see a physician. Some, in addition, perform a battery of tests which are not requested by an attending physician.

The physician's ethical responsibility is to provide his patient with high quality services. He should not utilize services of any testing program unless he has the utmost confidence in the quality of its services. He must assume professional responsibility for the best interest of the patient. As a professional man, the physician is entitled to compensation for his services. However, he should not be engaged in the commercial conduct of a testing or screening program and should not make a mark up commission or profit on services rendered by others. It is not, in itself, unethical for a physician to own an automated multiphasic facility or interest. The use the physician makes of this ownership may be unethical.

An attending physician may not receive a rebate, referral fee, or commission from a program whose facilities have been used by his patients.

An automated health testing facility is a fact finding and reporting system. It must be limited to fact finding and exclude interpretation. Findings disclosed must be interpreted only by physicians.

Offering a combination or medical and non-medical service to the public is to be avoided. The public may be confused as to what constitutes reporting a fact and what constitutes the making of a medical diagnosis.

A practicing physician may recommend multiphasic health testing where he believes it may be helpful to him in the care of his patient. Prudence dictates that the physician be selective in recommending or requiring patients to utilize the services of an automatic health testing facility and not adopt the practice of routinely requiring that all patients, or all new patients, undergo such testing. When good medical judgment suggests the desirability of such testing, the physician should explain in general the nature and purpose of the testing. The patient must be afforded freedom to choose between automated multiphasic health testing facilities, if available. Alternatives in the way of single tests should be offered patients, where possible and practical.

An individual who is tested, or a facility which conducts these tests, may neither demand that a physician accept an individual as a patient nor evaluate the tests for the individual. The physician remains free to choose whom he will serve.

A physician employed by an automated multiphasic health testing facility, in conformity with well established policies, should not dispose of his professional attainments to any corporation or to a lay body under terms or conditions which permit the sale of the services of that physician by an agency for fee, nor allow his name or the prestige of his professional status as a physician to be used in the promotion of a commercial enterprise. He should neither aid nor abet an unlicensed individual or corporation to practice medicine.

There is a responsibility for the medical society to educate the public regarding indications for and against multiphasic health testing, to educate the membership of the society regarding ethical responsibilities in these matters, and the society must be ready to assist persons or corporations that seek advice in setting up multiphasic health testing facilities.

An individual who is tested, or a facility which conducts these tests, may neither demand that a physician accept an individual as a patient nor evaluate the tests for the individual. The physician remains free to choose whom he will serve.

A physician employed by an automated multiphasic health testing facility, in conformity with well established policies, should not dispose of his professional attainments to any corporation or to a lay body under terms or conditions which permit the sale of the servcies of that physician by an agency for fee, nor allow his name or the prestige of his professional status as a physician to be used in the promotion of a commercial enterprise. He should neither aid nor abet an unlicensed individual or corporation to practice medicine.

There is a responsibility for the medical society to educate the public regarding indications for and against multiphasic health testing, to educate the membership of the society regarding ethical responsibilities in these matters, and the society must be ready to assist persons or corporations that seek advice in setting up multiphasic health testing facilities.

AMERICAN MEDICAL ASSOCIATION
Guidelines for Establishing and Operating Multiphasic Health Testing Programs

The following guidelines are recommended for use by physicians and medical societies in providing technical advice and assistance in the planning, development, implementation, and operation of multiphasic health testing programs:

1. Multiphasic health testing is a method of acquiring, storing, collating, and reproducing medical data on individual patients. The testing procedures are considered to be incomplete health services. Provisions must be made for a physician to interpret and evaluate this medical data base as an aid in continuing patient care.
2. The multiphasic testing program should meet applicable licensing requirements and be appropriately evaluated for quality control.
3. Physicians should be involved in the planning and development of testing programs, and the operation of all programs should be supervised by qualified physicians.
4. The system should be designed to make maximum use of allied health professionals and should utilize technical and automated techniques where justified.
5. For professional value and economic feasibility, the program should include tests that are simple, safe, easy to interpret, inexpensive and quick to perform, and that have acceptable sensitivity, specificity, high predictive value, and patient acceptance.
6. The testing system should include the following criteria: reliability, accuracy of output, saving of time of physicians and allied health personnel, adequate utilization, and sufficient flexibility for customization to physician and patient needs. The program should establish individual ethnic, geographic, and other variations of normal and abnormal patterns.
7. The program should provide for confidentiality of patient data.
8. The testing program should be used, where feasible, to meet otherwise unmet community health needs and should be integrated into the continuing health care system.
9. The testing program should be designed to meet various objectives such as diagnostic services, health maintenance, and guidance in management of ongoing illness including chronic disease.
10. Evaluation methodology should be built into the program to determine the acceptance and use, yield, false positives and false negatives, as well as the long-term effects of the program on illness and the need and demand for health services. The program should include a documented accounting system, at least for internal use, and a reasonable cost finding system that would allow for cost analysis and cost summaries.
11. The program should maintain freedom of choice for both the physician and the patient.

AMA DELEGATION

Delegates to the American Medical Association

Elected May 20, 1970
(to serve from Jan. 1, 1971 to Dec. 31, 1972)

Carl E. Clark
225 Edward Street, Sycamore 60178
H. Close Hesseltine
5807 South Dorchester, Chicago 60637
Maurice M. Hoeltgen
1836 West 87th Street, Chicago 60620
Joseph R. Mallory
Linck Clinic, Mattoon 61938
Francis W. Young
10025 S. Hamilton, Chicago, 60643

Elected May 19, 1971
(to serve from Jan. 1, 1972 to Dec. 1, 1973)

Jack Gibbs
175 South Main Street, Canton 61520
Theodore Grevas
1800 Third Avenue, Rock Island 61201
Morgan Meyer
573 South Lombard, Lombard 60148
Edward A. Piszczek
6410 North Leona, Chicago 60646
Harold A. Sofield
715 Lake Street, Oak Park 60301
Philip G. Thomsen
13826 Lincoln, Dolton 60419

Elected March 10, 1972
(to serve from Jan. 1, 1973, to Dec. 31. 1974)

Carl E. Clark
225 Edward St., Sycamore 60178
H. Close Hesseltine
5807 S. Dorchester, Chicago 60637
Maurice M. Hoeltgen
1836 W. 87th St., Chicago 60620
Joseph R. Mallory
Linck Clinic, Mattoon 61938
Theodore R. Van Dellen
435 N. Michigan Ave., Chicago 60611

★ ★ ★

Honorary Delegates

Walter C. Bornemeier
4665 Peterson Avenue, Chicago 60646

Edwin S. Hamilton
985 Cobb Street, Kankakee 60901

George F. Lull
2440 Lakeview Avenue, Chicago 60614

Burtis E. Montgomery
37 South Main Street, Harrisburg 62946

Alternate Delegates to the American Medical Association

Elected May 20, 1970
(to serve from Jan. 1, 1971 to Dec. 31, 1972)

Frank J. Jirka, Jr.
1507 Keystone Avenue, River Forest 60305
Joseph R. O'Donnell
444 Park, Glen Ellyn 60137
John Ring
511 E. Hawley St., Mundelein 60060
(Elected May 19, 1971, to fill unexpired term of Jack Gibbs)
Fred A. Tworoger
4753 Broadway, Chicago 60640
Theodore R. Van Dellen
435 North Michigan Avenue, Chicago 60611

Elected May 19, 1971
(to serve from Jan. 1, 1972 to Dec. 31, 1973)

Herschel Browns
4600 North Ravensood Avenue, Chicago 60640
William Lees
6518 North Nokomis, Lincolnwood 60646
George C. Shropshear
1525 East 53rd Street, Chicago 60615
Paul Sunderland
214 North Sangamon, Gibson City 60936
Glen Tomlinson
Cook County Hospital, Chicago
Charles K. Wells
117 North 10th Street, Mt. Vernon 62864

Elected March 10, 1972
(to serve from Jan. 1, 1973, to Dec. 31, 1974)

Alfred J. Faber
2110 Swainwood Dr., Glenview 60025
Frank J. Jirka, Jr.
1507 Keystone Ave., River Forest 60305
Eugene T. Leonard
1215 N. Alpine, Rockford 61107
John Ring
511 E. Hawley St., Mundelein 60060
Fred A. Tworoger
4753 Broadway, Chicago 60640

ISMS House of Delegates

OFFICIAL MEMBERS OF THE HOUSE WITH THE RIGHT TO VOTE

Officers of ISMS

President—Frank J. Jirka, Jr.
1507 Keystone, River Forest 60305
President-elect—Willard C. Scrivner
#2, 6600 W. Main, Belleville 62223
Secretary-Treasurer—Jacob E. Reisch
1129 S. 2nd St., Springfield 62704
Speaker of the House—Paul W. Sunderland
214 N. Sangamon St., Gibson City 60936
First Vice-President—Joseph Skom
707 N. Fairbanks, Chicago 60611
Second Vice-President—Glen Tomlinson
Fantus Clinic, Cook County Hospital,
1825 W. Harrison, Chicago 60612
Vice-Speaker of the House—Andrew J. Brislen
6060 S. Drexel Blvd., Chicago 60637

Board of Trustees

1st District—Joseph L. Bordenave 1974
1665 South St., Geneva 60134
2nd District—Allan L. Goslin 1974
712 N. Bloomington, Streator 61364
3rd District—David S. Fox 1973
20829 Green Center Court,
Olympia Fields 60461
Robert T. Fox 1973
2136 Robin Crest Lane, Glenview 60025
Eugene T. Hoban 1975
6429 North Ave., Oak Park 60302
Fredric D. Lake 1975
1041 Michigan Ave., Evanston 60202
William M. Lees 1974
6518 N. Nokomis, Lincolnwood 60646
George C. Shropshear 1974
1525 E. 53rd, Chicago 60615
Philip G. Thomsen 1974
13826 Lincoln, Dolton 60419
Frederick E. Weiss 1973
15643 Lincoln, Harvey 60426
Warren W. Young 1975
3450 Haweswood Dr., Crete 60417
4th District—Fred Z. White 1973
723 N. 2nd St., Chillicothe 61523
5th District—A. Edward Livingston 1973
219 N. Main, Bloomington 61701
6th District—Mather Pfeiffenberger 1975
State & Wall Streets, Alton 62002
7th District—Arthur F. Goodyear 1973
142 E. Prairie Ave., Decatur 62523
8th District—Eugene P. Johnson 1973
P.O. Box 68, Casey, 62420
9th District—Warren D. Tuttle 1975
203 N. Vine, Harrisburg 62946
10th District—Herbert Dexheimer 1975
301 S. Illinois, Belleville 62220
11th District—Joseph R. O'Donnell 1974
444 Park, Glen Ellyn 60137
Trustee-at-Large—Charles J. Jannings, III 1973
101 E. Center, Fairfield 62837

Representatives of County Societies

A complete listing of delegates and alternates to the ISMS House will appear with the convention program.

EX-OFFICIO MEMBERS OF THE HOUSE WITHOUT THE RIGHT TO VOTE

Past Presidents

J. Ernest Breed 1971
Everett P. Coleman 1945-1946
Edward W. Cannady 1970
Newton DuPuy 1968
Harlan English 1964
Edwin S. Hamilton 1962
H. Close Hesseltine 1961
James H. Hutton 1940
Charles J. Jannings, III 1972
Willis I. Lewis 1954
George F. Lull 1963
Burtis E. Montgomery 1966
Edward A. Piszczek 1965
Caesar Portes 1967
Leo P. A. Sweeney 1953
Philip G. Thomsen 1969
Arkell M. Vaughn 1955

Past Trustees

William E. Adams
Chicago, Trustee of the 3rd District
Earl H. Blair
Chicago, Trustee of the 3rd District
Walter C. Bornemeier
Chicago, Trustee of the 3rd District
Carl E. Clark
Sycamore, Trustee of the 1st District
Willard W. Fullerton
Sparta, Trustee of the 10th District
George E. Griffin
Princeton, Trustee of the 2nd District
Lee N. Hamm
Lincoln, Trustee of the 5th District
George A. Hellmuth
Chicago, Trustee of the 3rd District
Bernard Klein
Joliet, Trustee of the 11th District
Ted LeBoy
Chicago, Trustee of the 3rd District
Warner H. Newcomb
Jacksonville, Trustee of the 6th District
Ralph N. Redmond
Sterling, Trustee from the 2nd District
Paul P. Youngberg
Moline, Trustee of the 4th Dlstrict
Darrell H. Trumpe
Springfield, Trustee of the 5th District
William H. Schowengerdt
Champaign, Trustee of the 8th District
Charles K. Wells
Mr. Vernon, Trustee of the 9th District

Past Speakers

Walter C. Bornemeier, Chicago 1961-1964
Edward W. Cannady, Belleville 1964-1967
Maurice M. Hoeltgen, Chicago 1967-1970

Officers of County Medical Societies
1972

County	President	Secretary
Adams Members: 78-Dist. No. 6	William U. McReynolds 1101 Main St., Quincy, 62301	Julio delCastillo Illinois Bank Bldg., Quincy, 62301
Alexander Members: 7-Dist. No. 10	Paul Spence 800½ Commercial, Ave., Cairo, 62914	Charles L. Yarbrough 800 Commercial Ave., Cairo, 62914
Bond Members: 18-Dist. No. 7	Charles R. Daisy 308 W. College, Greenville, 62246	James Goggin 207 North Second, Greenville, 62246
Boone Members: 16-Dist. No. 1	M. Paul Dommers 1101 N. State St., Belvidere, 61108	Earl S. Davis 119 South State, Belvidere, 61108
Bureau Members: 24-Dist. No. 2	Louis D. Tarsinos 682 E. Peru, Princeton, 61356	Karl D. Nelson 101 Park Avenue, Princeton, 61356
Carroll Members: 7-Dist. No. 1	E. P. Mitchell 20 E. Market St., Shannon, 61078	B. V. Gunnarson P.O. Box 285, Savanna, 61074
Cass Members: 5-Dist. No. 6	R. A. Spencer 115 West 4th Street, Beardstown, 62618	A. G. Hyde 507 Washington St., Beardstown, 62618
Champaign Members: 190-Dist. No. 8	H. E. Wachter Christie Clinic, Champaign, 61820	Paul W. Yardy 1109 S. Lincoln Ave., Urbana, 61801
Christian Members: 18-Dist. No. 7	P. K. Hagen 311 S. Main St., Taylorville, 62568	J. W. Murphy 301 S. Webster St., Taylorville, 62568
Clark Members: 5-Dist. No. 8	Eugene P. Johnson P.O. Box 68, Casey, 62420	Charles G. Moore, Jr. Martinsville Clinic, Martinsville, 62442
Clay Members: 6-Dist. No. 7	A. Paul Naney Flora Clinic, Flora, 62839	Donald L. Bunnell Flora Clinic, Flora, 62839
Clinton Members: 11-Dist. No. 7	M. A. Batemann 541 - 9th St., Carlyle, 62231	F. H. Ketterer 289 N. Main St., Breese, 62230
Coles-Cumberland Members: 36-Dist. No. 8	Robert Swengel Box 340, Neoga, 62447	Jerry D. Heath 6 Orchard Dr., Charleston, 61920
Crawford Members: 15-Dist. No. 8	H. F. Iknaya 408 S. Cross, Robinson, 62454	W. B. Schmidt 408 S. Cross, Robinson, 62454
De Kalb Members: 50-Dist. No. 1	E. Carey Fountain Clinic, Sandwich, 60548	William Dechsler 225 Edwards St., Sycamore, 60178
De Witt Members: 9-Dist. No. 5	John W. Veirs 219 East Main St., Clinton, 61727	Charles Ramey 215 East Main St., Clinton, 61727
Douglas Members: 10-Dist. No. 8	Ricardo Isquierdo 108 E. Pembroke, Tuscola, 61953	Elmer S. Allen 120 S. Locust St., Arcola, 61910
Du Page Members: 399-Dist. No. 11 Lillian Widmer, Exec Sec. 646 Roosevelt Rd., Glen Ellyn, 60137	Jack S. Burton 172 Schiller, Elmhurst, 60126	James P. Campbell 322 N. Blanchard St., Wheaton, 60187
Edgar Members: 13-Dist. No. 8	Joseph R. Shackelford Medical Center Clinic, Paris, 61944	J. M. Ingalls 502 Shaw, Paris, 61944
Edwards Members: 2-Dist. No. 9	Paul S. Neirenberg 7 West Main St., Albion, 62806	Andrew Krajec Box 336, West Salem, 62476
Effingham Members: 19-Dist. No. 7	Ernest Frank St. Anthony Memorial Hosp., Effingham 62401	Frederick Reis 503 N. Maple, Effingham, 62401

County	President	Secretary
Fayette Members: 10-Dist. No. 7	S. W. Moore 1029 N. 8th St., Vandalia 62471	E. A. Kuehn 501½ West Gallatin, Vandalia, 62471
Ford Members: 11-Dist. No. 11	Clyde A. Rulison Roberts, 60962	William A. Garrett Sibley, 61773
Franklin Members: 23- Dist. No. 9	E. P. Mitchell Benton Medical Clinic Bldg, Benton, 62812	D. P. Richerson P.O. Box 99, Christopher, 62822
Fulton Members: 26-Dist. No. 4	W. K. Wilner Route 2, Cuba, 61427	M. E. Schmidt Graham Hospital, Canton, 61520
Gallatin Members: 3-Dist. No. 9	Wilbur Stanelle Shawneetown, 62984	John Doyle Ridgway, 62979
Greene Members: 7-Dist. No. 6	Gary L. Turpin 712 S. College Ave., Greenfield, 62044	James C. Reid Fillager Mem. Clinic, Greenfield, 62044
Hancock Members: 11-Dist. No. 4	Charles Eddingfield Memorial Hospital, Carthage, 62321	Elizabeth B. Korte 723 Questover Dr., Carthage, 62321
Henderson Members: 1-Dist. No. 4		Silvino Lindo, Jr. Biggsville, 61448
Henry-Stark Members: 25-Dist. No. 4	Roberto Puentes 100 E. Main St., Geneseo, 61254	Juan S. Puentes 115 W. Main, Atkinson, 61235
Iroquois Members: 18-Dist. No. 11	Bela Borsos 207 N. Axtel, Milford, 60953	S. D. Roeder 845 S. Fourth, Watseka, 60970
Jackson Members: 49-Dist. No. 10	Lelan E. Stallings 422 W. Jackson, Carbondale, 62901	Sidney G. Smith P.O. Box 1030, Carbondale Clinic Carbondale, 62901
Jasper Members: 2-Dist. No. 8	Don Hartrich Box 192, Newton, 62448	
Jefferson-Hamilton Members: 32-Dist. No. 9	David A. Nehme Southern Ill. Clinic, Mt. Vernon, 62864	Crile Doscher #1 Doctors Park Rd., Southern Ill. Clinic, Mt. Vernon, 62864
Jersey-Calhoun Members: 10-Dist. No. 6	Bernard Baalman Hardin, 62047	Larry Plummer Jerseyville, 62052
Jo Daviess Members: 10-Dist. No. 1	Lyle A. Rachuy 323 N. Main St., Stockton, 61085	Delbert O. Williams 323 North Main St., Stockton, 61085
Johnson Members: 1-Dist. No. 9		
Kane Members: 253-Dist. No. 1 Exec. Sec. J. Michael Fitzgerald 214½ W. State St., Geneva 60134	Fred H. Slager 860 Summit St., Elgin, 60120	James E. Habegger 32 South Lincoln Ave., Geneva, 60134
Kankakee Members: 92-Dist. No. 11	T. P. Hickey 555 S. Schuyler Ave., Kankakee, 60901	A. A. Palow 555 S. Schuyler Ave., Kankakee, 60901
Kendall Members: 8-Dist. No. 11	Joseph L. Daw Oswego Medical Group, Oswego, 60543	Suzanne M. Roscoe Oswego Medical Group, Oswego, 60543
Knox Members: 61-Dist. No. 4	Walter J. Zich St. Mary's Hosp., Galesburg, 61401	Juan E. Espejo Galesburg Cottage Hosp., Galesburg, 61401
Lake Members: 257-Dist. No. 7 Exec. Sec. Mrs. Julia P. Schulz P.O. Box 148, Gurnee 60031	John Andrews 1616 Grand Ave., Waukegan, 60085	David Helberg 1702 Washington St., Waukegan, 60085

County	President	Secretary
La Salle Members: 95-Dist. No. 2	T. Wagenknecht 111 Spring St., Streator, 61364	Allan L. Goslin 712 N. Bloomington, Streator, 61364
Lawrence Members: 9-Dist. No. 8	Robert J. Nichols P.O. Box 907, Vincennes, IN 47591	Charles G. Stoll 802 Jefferson St., Lawrenceville, 62439
Lee Members: 17-Dist. No. 2	Wayne F. Spenader Sublette, 61367	
Livingston Members: 28-Dist. No. 2	Theodore Mauger 416 E. Hickory, Chatsworth, 60921	Karl T. Deterding Bank of Pontiac Bldg., Pontiac, 61764
Logan Members: 22-Dist. No. 5	R. B. Perry 523 N. Elm St., Lincoln, 62656	E. A. Ulrich Forrest Hills, Lincoln, 62656
Macon Members: 138-Dist. No. 7	Charles O. Stanley 417 W. Wood St., Decatur, 62522	G. Richard Locke 2300 N. Edward St., Decatur, 62521
Macoupin Members: 20-Dist. No. 6	Lee L. Johnson 426 W. Pearl St., Staunton, 62088	Robert H. Rutherford 224 E. Main St., Carlinville, 62626
Madison Members: 123-Dist. No. 6	John H. Hooker Alton Memorial Hosp., Alton, 62002	Norman E. Taylor 95 S. 9th St., Rosewood Heights, 62024
Marion Members: 36-Dist. No. 7	F. C. Katzenstein 115 E. Rogers St., Salem, 62881	Walter P. Plassman Box 552, Centralia, 62801
Mason Members: 6-Dist. No. 5	Dario Landasuri 125 North Orange Street, Havana, 62644	Henry W. Maxfield Mason City, 62664
Massac Members: 5-Dist. No. 9	James L. Bremer 805 Market Street, Metropolis, 62960	Ralph K. Frazier Hospital Drive, Metropolis, 62960
McDonough Members: 24-Dist. No. 4	C. L. Weston 120 N. Dudley Street, Macomb, 61455	J. L. Symmonds 301 East Jefferson, Macomb, 61455
McHenry Members: 55-Dist. No. 1	August M. Rossetti 1110 N. Green Street, McHenry, 60050	Wm. R. Larsen 13707 W. Jackson St., Woodstock, 60098
McLean Members: 84-Dist. No. 5 David W. Meister, Exec. Sec. 427 1st Nat. Bank Bldg., Peoria 61602	Paul Theobald 429 N. Main, Bloomington, 61701	Douglas R. Bey 429 N. Main, Bloomington, 61701
Menard Members: 1-Dist. No. 5	Robert J. Schafer 116 N. 5th Street, Petersburg, 62675	
Mercer Members: 4-Dist. No. 5	Monty P. McClellan 309 NW 2nd Street, Aledo, 61231	James W. Hastings 301 NW 2nd St., Aledo, 61231
Monroe Members: 9-Dist. No. 10	Edelberto Maglasang 109 W. Legion Street, Columbia, 62236	Ingeborg M. Kremer 854 W. Bottom, Columbia, 62236
Montgomery Members: 16-Dist. No. 5	William T. Douglas 113 W. Wood St., Hillsboro, 62049	Rudolph Sommer 515 N. Monroe, Litchfield, 62056
Morgan-Scott Members: 41-Dist. No. 6	Theron R. Scobbie 1449 W. Walnut St., Jacksonville, 62650	Robert H. Kooiker 801 Lincoln Ave., Jacksonville, 62650
Moultrie Members: 5-Dist. No. 7	Eugene Boros Bethany, 61914	H. E. Kendall 112 E. Harrison, Sullivan, 61951
Ogle Members: 18-Dist. No. 1	Thomas L. Koritz 324 Lincoln Highway, Rochelle, 61068	Russell Zack 515 Lincoln Hwy., Rochelle, 61068

County	President	Secretary
Peoria Members: 258-Dist. No. 4 David W. Meister, Jr., Exec. Sec., 427 1st Nat. Bank Bldg., Peoria 61602	Dean R. Bordeaux 427 1st Nat. Bank Bldg., Peoria, 61602	Gene O. Hoerr 427 1st National Bank Bldg., Peoria, 61602
Perry Members: 16-Dist. No. 10	Clarence E. Cawvey 20 N. Main St., Pickneyville, 62274	Bill R. Fulk 207½ E. Main, DuQuoin, 62832
Piatt Members: 6-Dist. No. 7	George Green 340 N. State Street, Monticello, 61856	Joseph Allman 121 North State St., Monticello, 61856
Pike Members: 9-Dist. No. 6	Jack M. Bailis Pittsfield, 62363	B. J. Rodriguez 868 Mortimer, Barry, 62312
Pulaski Members: 1-Dist. No. 10	A. L. Robinson Box 277, Mounds, 62964	
Randolph Members: 16-Dist. No. 10	J. M. Whittenberg 840 State St., Chester, 62233	C. S. Schlageter 101 North Market, Sparta, 62286
Richland Members: 21-Dist. No. 8	Gerald M. Mastio Weber Medical Clinic, Olney, 62450	Richard O. Peach 1 Deveron Drive, Olney, 62450
Rock Island Members: 149-Dist. No. 4 James A. Koch, Exec. Sec. 612 Kahl Bldg., Davenport, 52801	Robert J. Graham 3637 23rd Ave., Moline, 61265	J. P. Johnston 1630 - 5th Ave., Moline, 61265
St. Clair Members: 198-Dist. No. 10 Ed Belz, Exec. Dir. 4825 W. Main St., Belleville 62223	Julian W. Buser 6600 W. Main St., Belleville, 62223	Mays Maxwell 4202 Bond St., East St. Louis, 62207
Saline-Pope-Hardin Members: 26-Dist. No. 9	Albert G. Bledig 1405 Locust St., Eldorado, 62930	Warren R. Dammers Bowen Children's Cen., Harrisburg, 62946
Sangamon Members: 214-Dist. No. 5 L. R. Brosi, Exec. Sec. 2100 Lindsay Rd., Springfield 62804	Darrell H. Trumpe 2412 Beardstown Rd., Springfield, 62702	Robert L. Prentice 701 N. Walnut, Springfield, 62702
Schuyler Members: 3-Dist. No. 4	R. R. Dohner 103 W. Washington, Rushville, 62681	Henry C. Zingher Rushville Clinic, Rushville, 62681
Shelby Members: 8-Dist. No. 4	Charles A. Spears 1218 W. Main St., Shelbyville, 62565	Smith D. Taylor 520 Penns Avenue, Windsor, 61957
Stephenson Members: 45-Dist. No. 1	J. E. Madden 420 S. Harlem Ave., Freeport, 61032	R. Samuel Hoover Box 573, Freeport, 61032
Tazewell Members: 46-Dist. No. 5 David W. Miester, Jr., Exec. Sec., 427 1st Nat. Bank Bldg., Peoria, 61602	Daniel E. Baer 427 1st Nat. Bank Bldg., Peoria 61602	Robert M. Wright 427 1st Nat. Bank Bldg., Peoria, 61602
Union Members: 6-Dist. No. 10	Robert L. Rader 200 N. Main St., Anna, 62906	William H. Whiting Box 410, Anna 62906
Vermilion Members: 80-Dist. No. 8	Malcom C. Spencer 605 N. Logan Ave., Danville, 61832	L. W. Tanner 7 North Virginia, Danville, 61832
Wabash Members: 7-Dist. No. 9	T. R. Young 512 Market St., Mt. Carmel, 62863	C. J. Johns 114 West 5th St., Mt. Carmel, 62863
Warren Members: 11-Dist. No. 9	Douglas W. Taylor 120 North A St., Monmouth, 61462	Glenn W. Chamberlin 219 E. Euclid St., Monmouth, 61462
Washington Members: 3-Dist. No. 10	Charles Longwell Nashville, 62263	Jerry L. Beguelin Irvington Medical Center, Irvington, 62848
Wayne Members: 6-Dist. No. 9	D. A. Gershenson 308 E. Main St., Fairfield, 62837	Edward S. Talaga 101 E. Center St., Fairfield, 62837
White Members: 7-Dist. No. 9	Phillip D. Boren 507 W. Main St., Carmi, 62821	Stanley B. Abelson S. Plum Street, Carmi, 62821

County	President	Secretary
Whiteside Members: 38-Dist. No. 2	Erwin J. Roubicek 307 1st Avenue, Sterling, 61081	Edward D. Greaves Sterling Rock Falls Clinic, Sterling, 61081
Will-Grundy Members: 192-Dist. No. 11 Exec. Sec. Don M. Kline 58 N. Chicago St., Joliet 60431	Merle L. Otto 58 N. Chicago St., Joliet 60431	Guy A. Pandola 58 N. Chicago St., Joliet, 60431
Williamson Members: 27-Dist. No. 9	Alden S. Thompson Herrin Hosp., Herrin, 62948	Herbert V. Fine 110 N. Division St., Carterville, 62918
Winnebago Members: 27-Dist. No. 9 Exec. Admin. D. A. Westbrook 310 N. Wyman St., Rockford 61101	John P. Locksmith 310 N. Wyman St., Rockford, 61101	Norman A. Hagman 310 N. Wyman St., Rockford, 61101
Woodford Members: 8-Dist. No. 2	Robert P. Lykkebak 399 West Front St., Elpaso 61738	James W. Riley 109 S. Major St., Eureka, 61530

No Organized County Society

Johnson
Marshall
Putnam

Joint County Societies

Coles-Cumberland
Henry-Stark
Jefferson-Hamilton
Jersey-Calhoun
Morgan-Scott
Saline-Pope-Hardin
Will-Grundy
Cass-Brown

Chicago Medical Society

President: Charles Weigel
7579 Lake Street, River Forest 60305
Secretary: Fredric Lake
2520 Lake View, Chicago 60614
Executive Vice-President: George Lull
310 S. Michigan Ave., Chicago 60604
Executive Director: Robert J. Lindley
310 S. Michigan Ave., Chicago 60604
Members 7,026 (including residents) District No. 3

Branch Officers

AUX PLAINES BRANCH
President: Joseph B. Moles
1011 W. Lake, Oak Park 60301
Secretary: Meredith B. Murray
414 S. Oak Park, Oak Park 60302

CALUMET BRANCH
President: Robert J. Craven
9760 S. Kedzie, Evergreen Park 60642
Secretary-Treasurer: Edwin L. Falloon
9450 S. Francisco, Evergreen Park 60642

DOUGLAS PARK BRANCH
President: Jaroslav F. Neskodny
3128 Wisconsin Ave., Berwyn 60402
Secretary: Fabian F. Ostrowski
3601 S. Austin Blvd., Cicero 60650

ENGLEWOOD BRANCH
President: Thomas P. Driscoll
7800 W. 87th St., Chicago 60652
Secretary-Treasurer: Kenneth M. Wilcox
10444 S. Kedzie, Chicago 60655

NORTH SUBURBAN BRANCH
President: Stanley E. Huff
454 Sheridan Rd., Winnetka 60093
Secretary-Treasurer: Leon L. Ampel
2701 Oak St., Northbrook 60052

IRVING PARK SUBURBAN BRANCH
President: Martin P. Meisenheimer
107 E. McDonald Rd., Prospect Hts. 60070
Secretary: Herman L. Wing
400 E. Randolph, Chicago 60601

JACKSON PARK BRANCH
President: Richard J. Jones
4820 S. Kenwood Ave., Chicago 60615
Secretary-Treasurer: Helen Cook Newman
1534 E. 59th St. 60637

NORTH SHORE BRANCH
President: William O. Ackley
2439 Foster, Chicago 60025
Secretary: Clarke W. Mangan, Jr.
733 S. Greenwood, Park Ridge 60068

NORTH SIDE BRANCH
President: C. Larkin Flanagan
720 N. Michigan 60611
Secretary-Treasurer: Joseph C. Sherrick
303 E. Superior St. 60611

NORTH SUBURBAN BRANCH
President: Stanley E. Huff
454 Sheridan Rd., Winnetka 60093
Secretary: Leon M. Ampel
2701 Oak St., Northbrook 60002

NORTHWEST BRANCH
President: Alfanso Diaz
1802 S. Racine, Chicago 60608
Secretary-Treasurer: Theodore R. Tenczar
6324 N. Milwaukee, Chicago 60646

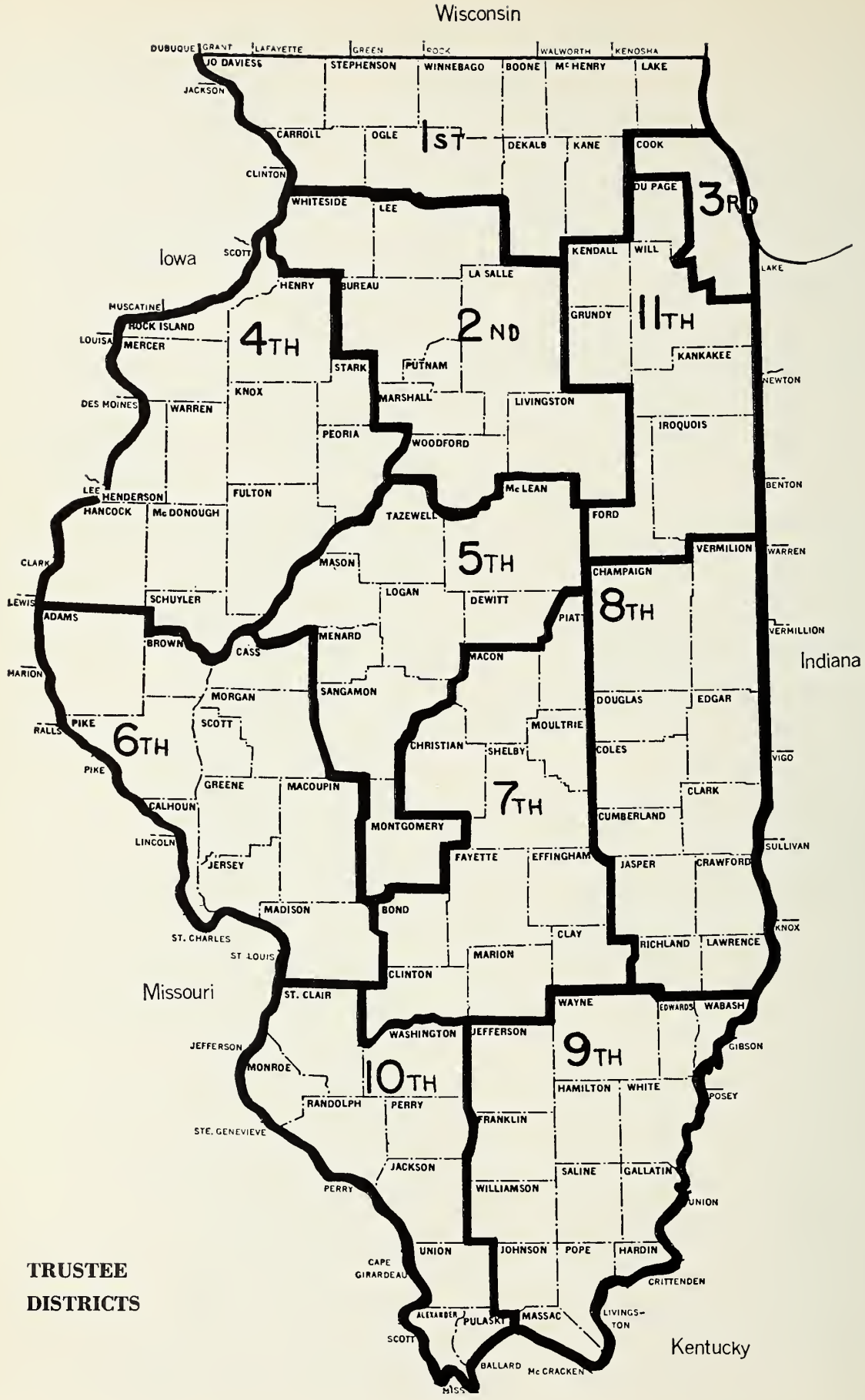
SOUTH CHICAGO BRANCH
President: Vincent A. Constanzo, Jr.
8700 S. Dante Ave., Chicago 60619
Secretary-Treasurer: Anthony C. Guzauskas
10137 S. Hoyne, Chicago 60643

SOUTH SIDE BRANCH
President: Kermit Mehlinger
4901 Drexel Blvd. 60615
Secretary: Otto J. Keller
5825 S. Dorchester Ave. 60637

SOUTHERN COOK COUNTY BRANCH
President: Aaron B. Gerber
3630 Osage, Park Forest 60566
Secretary-Treasurer: Abraham Gelperin
18849 Jamie Ct., Homewood 60430

STOCK YARDS BRANCH
President: Maurice M. Hoeltgen
1836 West 87th St. 60620
Secretary-Treasurer: Edwin J. Lukaszweski
1213 W. 51st, Chicago 60609

WEST SIDE BRANCH
President: William J. Tansey
414 S. Oak Park Ave., Oak Park 60303
Secretary-Treasurer: Eugene T. Hoban
6429 North Ave., Oak Park 60302


Wisconsin
DUBUQUE
GRANT
LAFAYETTE
GREEN
ROCK
WALWORTH
KENOSHA
JO DAVIESS
STEPHENSON
WINNEBAGO
BOONE
McHENRY
LAKE
JACKSON
CARROLL
OGLE
1ST
DEKALB
KANE
COOK
CLINTON
DU PAGE
3RD
WHITESIDE
LEE
Iowa
SCOTT
KENDALL
WILL
LAKE
LA SALLE
HENRY
BUREAU
MUSCATINE
GRUNDY
11TH
ROCK ISLAND
4TH
2ND
LOUISA
MERCER
KANKAKEE
STARK
PUTNAM
NEWTON
KNOX
DES MOINES
WARREN
MARSHALL
LIVINGSTON
PEORIA
IROQUOIS
WOODFORD
LEE
HENDERSON
FULTON
McLEAN
BENTON
HANCOCK
McDONOUGH
TAZEWELL
FORD
5TH
VERMILION
WARREN
CLARK
MASON
CHAMPAIGN
LEWIS
SCHUYLER
LOGAN
DEWITT
8TH
ADAMS
PIATT
VERMILLION
BROWN
CASS
MENARD
Indiana
MACON
MARION
MORGAN
SANGAMON
DOUGLAS
EDGAR
PIKE
SCOTT
MOULTRIE
CHRISTIAN
SHELBY
COLES
6TH
VIGO
PIKE
GREENE
MACOUPIN
7TH
CLARK
CALHOUN
CUMBERLAND
MONTGOMERY
LINCOLN
SULLIVAN
JERSEY
FAYETTE
EFFINGHAM
JASPER
CRAWFORD
MADISON
BOND
KNOX
ST. CHARLES
CLAY
RICHLAND
LAWRENCE
ST. LOUIS
MARION
CLINTON
Missouri
ST. CLAIR
WAYNE
EDWARDS
WABASH
WASHINGTON
JEFFERSON
9TH
GIBSON
JEFFERSON
MONROE
10TH
HAMILTON
WHITE
POSEY
RANDOLPH
PERRY
FRANKLIN
STE. GENEVIEVE
JACKSON
SALINE
GALLATIN
PERRY
WILLIAMSON
UNION
UNION
JOHNSON
POPE
HARDIN
CAPE GIRARDEAU
CRITTENDEN
ALEXANDER
PULASKI
MASSAC
LIVINGSTON
SCOTT
Kentucky
BALLARD
McCRACKEN
TRUSTEE
DISTRICTS

TRUSTEE DISTRICT COMMITTEES

First District

Joseph L. Bordenave, Geneva, *Trustee*
Counties of Boone, Carroll, DeKalb, Jo Daviess, Kane, Lake, McHenry, Ogle, Stephenson, Winnebago

Ethical Relations Committee	Term Expires
John H. Steinkamp, *Chairman*	1975
Gerald Liesen, St. Charles	1973
James C. Ellis, DeKalb	1974
Paul Burkholder, Rockford	1975

Peer Review Committee

Russell Zack, Rochelle, *Chairman*	1973
Charles Picus, Rockford	1975
Walter J. Reedy, Waukegan	1975
John E. Madden, Freeport	1973
Rodney Nelson, Geneva	1975
Erwin A. Schilling, Rockford	1975
R. E. Whitsitt, Rockford	1975

Second District

Allan L. Goslin, Streator, *Trustee*
Counties of Bureau, LaSalle, Lee, Livingston, Marshall, Putnam, Whiteside, Woodford

Ethical Relations Committee	Term Expires
K. Dexter Nelson, Princeton, *Chairman*	1974
William Erkonen, Streator	1975
Tim Sullivan, Sterling	1973

Peer Review Committee

K. M. Nelson, Princeton, *Chairman*	1975
M. D. Burnstine, Sterling, *Co-Chairman*	1973
James B. Aplington, LaSalle	1973
LaMonte Ballard, Sterling	1973
Francis J. Brennan, Utica	1973
Silvio Davito, Spring Valley	1973
Bernard J. Doyle, LaSalle	1973
Donald Edwards, Dixon	1973
William Ehling, Streator	1974
Julius Kolis, Dixon	1973
P. Lymberopoulis, Dixon	1973
Edward Murphy, Dixon	1974
Rowland Musick, Mendota	1973
Theodore Mauger, Chatsworth	1975
Goodwin Taraason, Peru	1973
Louis Tarsinos, Princeton	1973
Philip Terry, Kewanee	1973
Theodore W. Wagenknecht, Streator	1973

Third District

David S. Fox, Olympia Fields, *Trustee*
Robert T. Fox, Glenview, *Trustee*
Eugene T. Hoban, Oak Park, *Trustee*
Fredric D. Lake, Evanston, *Trustee*
William M. Lees, Lincolnwood, *Trustee*
George Shropshear, Chicago, *Trustee*
Philip G. Thomsen, Dolton, *Trustee*
Frederick E. Weiss, Harvey, *Trustee*
Warren Young, Crete, *Trustee*
No district committees are appointed

Fourth District

Fred Z. White, Chillicothe, *Trustee*
Counties of Fulton, Hancock, Henderson, Henry, Knox, McDonough, Mercer, Peoria, Rock Island, Schuyler, Stark, Warren

Ethical Relations Committee	Term Expires
Richard Icenogle, Roseville, *Chairman*	1974
John Bowman, Abingdon	1973
George Burke, Rock Island	1975

Peer Review Committee

Russell Jensen, Monmouth, *Chairman*	1973
William Daugherty, Moline	1975
Donald Dexter, Macomb	1974
G. W. Giebelhausen, Peoria	1975
James C. Parsons, Geneseo	1973
Clarence Ward, Peoria	1975

Fifth District

A. Edward Livingston, Bloomington, *Trustee*
Counties of DeWitt, Logan, McLean, Mason, Menard, Montgomery, Sangamon, Tazewell

Ethical Relations Committee	Term Expires
William W. Curtis, Springfield, *Chairman*	1974
A. L. Van Ness, Bloomington	1973
Jack Means, Mason City	1975

Peer Review Committee

James Borgerson, Mt. Pulaski, *Chairman*	1974
Robert Price, Bloomington, *Co-Chairman*	1974
Ross Billiter, Litchfield	1973
George Irwin, Bloomington	1973
John G. Meyer, Springfield	1975
Alton J. Morris, Springfield	1973
Robert B. Perry, Lincoln	1973
Robert Schaefer, Petersburg	1975
James Weimer, Pekin	1973

Sixth District

Mather Pfeiffenberger, Alton, *Trustee*
Counties of Adams, Brown, Calhoun, Cass, Green, Jersey, Macoupin, Madison, Morgan, Pike, Scott

Ethical Relations Committee	Term Expires
George F. Dietz, Granite City, *Chairman*	1973
Bernard Baalman, Hardin	1975
Edward K. DuVivier, Alton	1974
Joseph J. Grandone, Gillespie	1974
Lee Johnson, Staunton	1975

Peer Review Committee

Robert R. Hartman, Jacksonville, *Chairman*	1975
Meyer Shulman, Pittsfield, *Co-Chairman*	1974
E. C. Bone, Jacksonville	1973
Bruno DeSulis, Beardstown	1974
Robert C. Murphy, Quincy	1973
Frank B. Norbury, Jacksonville	1975
James Reid, Greenfield	1974
James W. Sutherland, Quincy	1974
A. D. Wilson, Carrollton	1975

Seventh District

Arthur F. Goodyear, Decatur, *Trustee*
Counties of Bond, Christian, Clay, Clinton, Effingham, Fayette, Macon, Marion, Moultrie, Piatt, Shelby

Ethical Relations Committee	Term Expires
Carl Sandburg, Decatur, *Chairman*	1973
Max Hirschfelder, Centralia	1974
E. H. Rames, Vandalia	1975

Peer Review Committee	
Stanley Moore, Vandalia, *Chairman*	1973
E. C. Bartelsmeyer, Taylorville	1974
H. O. Hoffman, Decatur	1974
Walter P. Plassman, Centralia	1973
William Sargeant, Effingham	1973

Eighth District

Eugene P. Johnson, Casey, *Trustee*
Counties of Champaign, Clark, Coles, Crawford, Cumberland, Douglas, Edgar, Jasper, Lawrence, Richland, Vermillion

Ethical Relations Committee	Term Expires
Mack W. Hollowell, Charleston, *Chairman*	1974
James H. Pass, Olney	1972
Alan M. Taylor, Danville	1973

Peer Review Committee	
A. R. Brandenberger, Danville, *Chairman*	1974
James W. Landis, Olney, *Co-Chairman*	1974
Eugene Johnson, Casey	1975
E. A. Kendall, Mattoon	1973
George T. Mitchell, Marshall	1975
Gordon Sprague, Paris	1973

Ninth District

Warren D. Tuttle, Harrisburg, *Trustee*
Counties of Edwards, Franklin, Gallatin, Hamilton, Hardin, Jefferson, Johnson, Massac, Pope, Saline, Wabash, Wayne, White, Williamson

Ethical Relations Committee	Term Expires
Andrew Krajec, West Salem, *Chairman*	1973
Crile Dosher, Mt. Vernon	1975
Denton Farrell, Eldorado	1974

Peer Review Committee	
C. J. Jannings, III, Fairfield, *Chairman*	1973
Philip Boren, Carmi	1974
James Durham, Benton	1975
Herbert Fine, Carterville	1975
Ernest Lowenstein, Mt. Carmel	1973
Charles K. Wells, Mt. Vernon	1975

Tenth District

Herbert Dexheimer, Belleville, *Trustee*
Counties of Alexander, Jackson, Monroe, Perry, Pulaski, Randolph, St. Clair, Union, Washington

Ethical Relations Committee	Term Expires
A. L. Robinson, Mounds, *Chairman*	1973
William Borgsmiller, Murphysboro	1975
Peter Soto, Belleville	1974

Peer Review Committee	
Joseph A. Petrazio, Murphysboro, *Chairman*	1973
George Cutridge, DuQuoin, *Co-Chairman*	1973
Charles Baldree, Belleville	1973
Eli Borken, Carbondale	1973
R. W. Jost, Waterloo	1975
B. Kinsman, DuQuoin	1973
Robert Rader, Anna	1974
R. E. Schettler, Red Bud	1974
William H. Walton, Belleville	1975
Charles L. Yarbrough, Cairo	1973

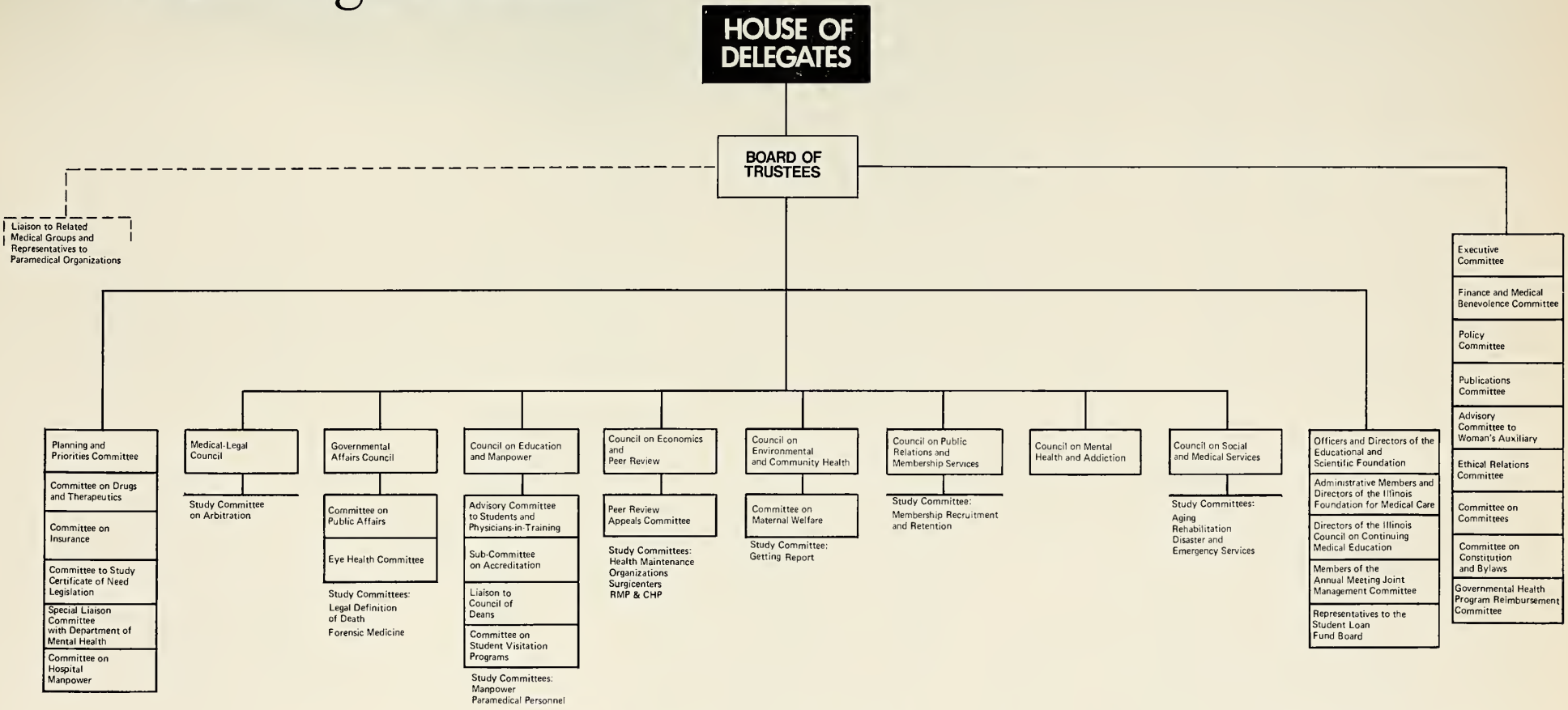
Eleventh District

Joseph R. O'Donnell, Glen Ellyn, *Trustee*
Counties of DuPage, Ford, Grundy, Iroquois, Kankakee, Kendall, Will

Ethical Relations Committee	Term Expires
James Ryan, Kankakee, *Chairman*	1975
John Bowden, Joliet	1973
Lawrence D. Lee, Manhattan	1973

Peer Review Committee	
James Campbell, Wheaton, *Chairman*	1975
James E. Dailey, Watseka	1975
James Lambert, Joliet	1973
Guy Pandola, Joliet	1975
William C. Perkins, West Chicago	1973
Julius Schweitzer, Hinsdale	1974
Victor Smith, Newark	1974

ISMS Organization



Councils of the Illinois State Medical Society

Councils of the Illinois State Medical Society are appointed by the Chairman of the Board of Trustees subject to approval of the Board of Trustees. The councils are composed of such members as are necessary to accomplish the purposes of the council. Some committees are composed of members of the Board of Trustees and are designated Board Committees. Some committees may report directly to the board and are not assigned to a council. Task Forces are established to address a particular problem or concern which crosses areas of responsibility of the several councils. The task forces report directly to the board, as do representatives to various other agencies. The President, President-Elect, Speaker of the House, and Chairman of the Board are, by virtue of their office, ex-officio members of all groups.

COUNCIL ON ECONOMICS & PEER REVIEW

Fred A. Tworoger, *Chairman*
4753 Broadway, Chicago 60640
Charles E. Baldree, Jr.
26 E. Washington, Belleville 62220
Robert J. Becker
58 N. Chicago, Joliet 60431
Edward DuVivier
900 Brown St., Alton 62002
John L. Eaton
2855-18th St. C, Moline 61265
Earl E. Fredrick, Jr.
10830 Halsted St., Chicago 60628
R. Gregory Green
1355 Charles St., Rockford 61108
Don Michels
533 W. North, Elmhurst 60612
George Perlstein
391 E. Springfield, Champaign 61820
Maynard Shapiro
7531 Stony Island, Chicago 60649
Earl Walker
215 E. Locust, Harrisburg 62846

CONSULTANTS:

David Fox
20829 Greenwood Ct., Olympia Fields 60461
Eugene P. Johnson
P.O. Box 68, Casey 62420
Joseph R. O'Donnell
444 Park, Glen Ellyn 60137
Glen E. Tomlinson
Fantus Clinic, Cook County Hospital
1825 W. Harrison St., Chicago 60612
Frederick E. Weiss
15643 Lincoln, Harvey 60426
Fred Z. White
723 N. Second St., Chillicothe 61523

SAMA REPRESENTATIVES:

Wayne Domin, U. of I.
730 Smoke Tree St., Deerfield 60015
Michael Sandove, Loyola Univ.
1021 Lathrop, River Forest 60205

STAFF:

Joseph J. Lotharius

Committee:

Peer Review Appeals

Responsibilities and Purposes

The Council on Economics & Peer Review shall concern itself with: 1) relations with the health insurance industry and prepayment plans; 2) fees and fee adjudication as promulgated by the ISMS; 3) health care cost and utilization; 4) new modes of health care delivery (HMOs, prepaid programs); 5) health care planning programs (CHP, IRMP, etc.), 6) serving as the appellate body for peer review in the state to consider cases appealed from local and district peer review committees involving the quality and quantity of medical care.

COMMITTEE ON GOVERNMENTAL HEALTH PROGRAM REIMBURSEMENT

Joseph R. O'Donnell, *Chairman*
444 Park, Glen Ellyn, 60137
Herbert Dexheimer
301 S. Illinois, Belleville, 62220
Eugene P. Johnson
P.O. Box 68, Casey, 62420
George Shropshear
1525 E. 53rd, Chicago, 60615
Philip G. Thomsen
13826 Lincoln, Dolton 60419
Frederick E. Weiss
15643 Lincoln, Harvey, 60426
Jacob E. Reisch
1129 S. 2nd St., Springfield, 62704

STAFF: Joseph J. Lotharius

Responsibilities and Purposes:

The responsibilities of the Committee on Governmental Health Program Reimbursement will be to consider all problems of physician reimbursement by the government health programs—Medicare, Medicaid and CHAMPUS.

COUNCIL ON EDUCATION AND MANPOWER

Jack L. Gibbs, *Chairman*
175 S. Main St., Canton 61520
Morgan Meyer, *Vice Chairman*
815 S. Main, Lombard 60148
Herschell L. Browns
4600 N. Ravenswood, Chicago 60640
Lawrence L. Hirsch
836 Wellington, Chicago 60657
J. Ernest Breed
(Liaison to Illinois Council on CME)
55 E. Washington St., Chicago 60602
Allison Burdick, Jr.
(Adv. to Physicians-in-training)
1637 N. Mobile Ave., Chicago 60639
Gerald M. Berkowitz
1031 Cobblestone Ct., Northbrook 60062
Ross Hutchison
(Licensure)
126 E. Ninth St., Gibson City 60936
George O. Dohrmann
3000 Logan Blvd., Chicago 60647
Rex McMorris
619 N. E. Glen Oak Ave., Peoria 61603
John Holland
700 N. 7th, c/o Physicians Grp., Springfield 62702
L. P. Johnson
1335 Charles St., Rockford 61108
Donald Stehr
(Student Loan Fund)
102 E. Market, Havana 62644

CONSULTANTS:

Robert T. Fox
2136 Robin Crest Lane, Glenview 60025
Fred Z. White
723 N. 2nd St., Chillicothe 61523
Allan L. Goslin
712 N. Bloomington, Streator 61364

SAMA Representatives:

Jeff Waitzman, U. of I.
1431 W. Farwell, Chicago 60626
Michael Hughey, Loyola
711 Laural Ave., Wilmette 60091

Representatives of Medical Schools:

Chicago Medical School
James Shaffer, Ds.D.
2020 Ogden Ave., Chicago 60612
Loyola Medical School Stritch School of Medicine
William B. Rich
2160 S. 1st, Maywood 60153
University of Southern Illinois Medical School
Richard H. Moy, Dean
715 E. Carpenter, Springfield 62702
Rush Medical School
John Graettinger
Rush Presbyterian St. Lukes Medical Center,
Chicago 60612
Univ. of Illinois Peoria Medical School
Nicholas J. Cotsonas, Dean
U. of I Med. Center, Box 6998,
Chicago 60680
Univ. of Illinois Rockford Medical School
Robert L. Evans, Dean
1601 Park View, Rockford 61101

Northwestern Medical School
Jacob R. Suker
303 E. Chicago, Chicago 60611

University of Chicago—Pritzker School of Medicine

University of Illinois—Abraham Lincoln School of Med.

Staff: Richard A. Ott

Responsibilities and Purposes:

The Council on Education and Manpower shall study and evaluate all phases of medical education, including the development of programs by and for ISMS, and review programs for paramedical personnel. It shall carry to the deans of medical schools recommendations from the viewpoint of the practicing physician. It shall evaluate available postgraduate programs, advise the Illinois Dept. of R&E, and review hospital oriented education programs. Liaison shall be maintained with the advisory committee to students and physicians-in-training and with loan programs for medical students. Activities regarding physician distribution and retention shall also be within the scope of the Council, as well as medical licensure as it relates to education.

Committees:

Accreditation
Manpower
Liaison to Council of Deans
Paramedical Personnel
Advisory Committee to Students and Physicians-in-Training
Student Visitation Program

MANPOWER SUBCOMMITTEE

Council Members:

Morgan Meyer, *Chairman*
Rex O. McMorris
Donald Stehr

Non Council Members:

George Shropshear, Consultant
1525 E. 53rd St., Chicago 60615

Allan Goslin, Consultant
712 N. Bloomington, Streator 61364

Kermit Mehlinger
4901 S. Drexel Blvd., Chicago 60615

Michael Hughey, SAMA
711 Laural Ave., Wilmette 60091

Staff: James Slawny

ACCREDITATION SUBCOMMITTEE

Council Members:

Herschell Browns, *Chairman*
Ross Hutchison

Non-Council Members:

John Huss
172 Schiller St., Elmhurst 60126
Philip Bashook, Ph.D.
Center for Educational Development
University of Illinois, Box 6998, Chicago

Staff: Richard A. Ott

LIAISON COMMITTEE to the COUNCIL OF DEANS

Jack L. Gibbs,
John M. Holland

Edward G. Ference
932 S. 2nd Street, Springfield 62704

STUDENT VISITATION PROGRAMS SUBCOMMITTEE

Council members:

Gerald Berkowitz, *Chairman*
Allison Burdick, Jr.
Non-Council Members:

Jeff Waitzman, SAMA
1431 W. Farwell, Chicago 60626
Armand Littman, Consultant
505 Lake Shore Drive, Chicago 60611
William R. Best
367 Blythe, Riverside 60546

Staff: Perry L. Smithers

ADVISORY COMMITTEE TO MEDICAL STUDENTS AND PHYSICIANS-IN-TRAINING

Council Members:

Allison Burdick, Jr., *Chairman*
Lawrence Hirsch

Non-Council members:

Carl Barthelemy
175 S. Main St., Canton 61520
Kenneth Campione
670 N. Michigan Ave., Chicago 60611
N. Kenneth Furlong
221 N. GlenOak Ave., Peoria 61603
Jerry Ingalls
Medical Center Clinic, Paris 61944

Student Representatives:

Michael Hughey (Loyola)
711 Laurel Ave., Wilmette 60091
Frank Matheu (Chicago School of Osteopathic Medicine)
4904 S. Kedvale 60632
Boyd McCracken (Chicago Medical School)
433 S. Lombard, Oak Park 60302
Alan M. Roman (Chicago Medical School) (MECO)
943 Washington Blvd., Chicago 60302
Jeff Waitzman (Illinois)
1431 W. Farwell, Chicago 60626
Bob Waxler (Chicago Medical School)
2856 N. Clark St., Chicago 60657
Wm. Yasnoff (Northwestern University)
219 Augusta, Oak Park 60302

STAFF: Perry L. Smithers

COUNCIL ON ENVIRONMENTAL AND COMMUNITY HEALTH

Edward A. Piszczek, *Chairman*
6410 N. Leona, Chicago 60646
John Ballenger
(*Liaison with EENT and otolaryngology societies*)
723 Elm St., Glencoe 60093
Dan Butcher
365 Laurel Ave., Elmhurst 60126
James P. Campbell
322 N. Blanchard, Wheaton 60187
Thomas Davison
(*Liaison with industrial medicine*)
Chicago and North Western Railway Co.
17 North Clinton St., Chicago 60658
Eugene F. Diamond
(*Nutrition Conference Coordinator*)
11055 S. St. Louis Ave., Chicago 60658
Robert Hartman
(*Comm. on Maternal Welfare*)
1515A W. Walnut, Jacksonville 62650
Julius Kowalski
(*Liaison with environmental groups*)
436 Park Ave., E., Princeton 61356
Daniel Pachman
(*Liaison with Pediatric Coordinating Council*)
1212 N. Lake Shore Drive, Chicago
Arthur E. Sulek
Ill. Dept. of Public Health
4302 N. Main, Rockford 61103

CONSULTANTS:

Warren W. Young
3450 Haweswood, Crete 60417
Eugene T. Hoban
6429 North Ave., Oak Park 60302
Roger F. Sondag
State of Illinois, Dept. of Public Health
535 W. Jefferson St., Springfield 62706

AUXILIARY REPRESENTATIVE:

Mrs. William A. Schowengerdt
Rt. 2, S. Prospect Rd., Champaign 61820

SAMA REPRESENTATIVE:

Richard Hector, Loyola
918 N. 5th Ave., Maywood 60153

STAFF: H. Michael Wild

Responsibilities and Purposes:

The Council on Environmental & Community Health shall cooperate with the Illinois Department of Public Health in specific areas. Its responsibilities shall include the maintenance, protection and improvement of the health of the people of Illinois through organized community efforts.

It shall serve as a source of information on chronic illness and communicable diseases and cooperate with institutions and voluntary health agencies in disseminating such information.

It is responsible for medicine's interest in the relationship of man to his surroundings, particularly air, water and soil pollution; health problems related to population growth, urbanization and technological development bearing on the ecology of man.

The council also shall be concerned with diseases and problems associated with occupational and industrial health, cooperate with the Council on Occupational Health of AMA, Industrial Medical Association and similar state agencies and to recommend to the State of Illinois Workman's Compensation Board medical procedures designed to assist the board in the evaluation of claims.

Committees:

Getting Report Study Committee
Maternal Welfare

COMMITTEE ON MATERNAL WELFARE

Robert R. Hartman, *Chairman*
1515A W. Walnut St., Jacksonville 62650
Frederick H. Falls, *Chairman Emeritus and Special Consultant*
Box 47, River Forest 60305

DISTRICTS MEMBERS AND ALTERNATES

(alternates in italics)

1. William R. Larsen
13707 E. Jackson, Woodstock 60098
Gordon T. Burns
2300 N. Rockton, Rockford 61101
2. William J. Farley
710 Peoria St., Peru 61354
Donald M. Gallagher
Box 538, Granville 61326
3. Melvin Goodman
13826 Lincoln Ave., Dolton 60419
Charles F. Kramer
12647 S. Justine St., Calumet Park 60643

4. V. B. Adams
301 E. Jefferson, Macomb 61455
Ralph Gibson
416 St. Marks Ct., Peoria 61603
5. William W. Curtis
100 W. Miller, Springfield 62702
Robert Maletich
1025 S. 7th St., Springfield 62703
6. Robert R. Hartman
1515A Walnut St., Jacksonville 62650
Richard Yoder
601 E. 3rd, Alton 62002
7. Paul A. Raber
149 W. King, Decatur 62521
Hubert Magill
1170 E. Riverside, Decatur 62521
8. John C. Mason Jr.
715 N. Logan, Danville 61832
J. Roger Powell
602 W. University, Urbana 61801
9. William B. Skaggs
Doctor's Clinic, 203 N. Vine, Harrisburg 62946
Donald R. Risley
319 Market St., Mt. Carmel 62863
10. Arthur A. Smith
306 E. Eighth St., O'Fallon, 62269
William J. Malony
Box 1030, Carbondale 62901
11. John J. McLaughlin
2100 Glenwood, Joliet 60435
Charles P. Westfall
172 Schiller, Elmhurst 60126

Consultant

John Louis
10721 S. Hoyne, Chicago 60643
Willard C. Scrivner
Suite #2, 6600 W. Main St.
Belleville 62223
Augustant Webster
707 N. Fairbanks Ct., Chicago 60611
Franklin D. Yoder
535 W. Jefferson, Springfield 62707

STAFF: Richard A. Ott

GOVERNMENTAL AFFAIRS COUNCIL

Alfred J. Faber, *Chairman*
2100 Swainwood Dr., Glenview 60025
Theodore Balsam
4640 N. Marine Drive, Chicago 60640
Maurice Colbert
4600 N. Ravenswood, Chicago
Edward G. Ference
932 S. 2nd, Springfield 62704
Frank Holman
Christian Welfare Hospital, E. St. Louis 62201
Grant C. Johnson
Memorial Hospital, Springfield
Warren W. Kreft
940 Lee St., Des Plaines 60016
James Laidlaw
1005 Lincolnshire Dr., Champaign 61820
Jerome Neustadt
6 N. Michigan Ave., Chicago
John W. Ovitz
204 W. Elm St., Sycamore 60178
Robert Pierce
2420 Spring Brook Ave., Rockford
George Wilkins
3165 Myrtle, Granite City

CONSULTANTS:

Robert Fox
2136 Robin Crest, Glenview 60025
C. J. Jannings, III
101 Center St., Fairfield
Willard C. Scrivner
66 W. Main, Belleville
George Shropshear
1525 E. 53rd St., Chicago
Warren Tuttle
203 N. Vine, Harrisburg 62946

AUXILIARY REPRESENTATIVE:

Pam Taylor
1607 N. Vermillion, Danville

SAMA REPRESENTATIVES:

Chris Gilman
827SRH 818 S. Wolcott, Chicago
Tom Powers
440 E. Crescent, Elmhurst

STAFF:

J. Bernie Robinson
L. Booth
B. Kararo

Responsibilities and Purposes

1. Keep the Society and its members aware of all state and federal legislation and laws affecting the health of citizens of Illinois and the practice of medicine in Illinois.

2. Promulgate legislation to improve the health care of citizens of Illinois and the practice of medicine in Illinois.

3. Cooperate with the AMA in similar programs.

4. Develop programs to educate the public and the Illinois State Medical Society membership in the privileges and responsibilities of citizenship.

Committees:

Public Affairs
Eye Health
Forensic Medicine
Legal Definition of Death

EYE HEALTH COMMITTEE

Council Member:

Warren W. Kreft, *Chairman*
940 Lee St., Des Plaines 60016

Non-Council Members:

Frederick Crowley
1008 N. Main, Bloomington 61701

Marshall Hirshman
7841 West Church St., Morton Grove 60053

Maurice M. Hoeltgen
1836 West 87th St., Chicago 60620

Paul Hauser
2500 Ridge Ave., Evanston 60201

Edward Kwedar
615 S. 7th, Springfield 62703

Samuel Schall
30 N. Michigan, Chicago 60602

Frank Snell
334 West Main, Decatur 62522

STAFF: Larry Booth

AD-HOC COMMITTEE ON FORENSIC MEDICINE

Council Member:
Grant C. Johnson, M.D., *Chairman*
Non-Council Members:
Thomas P. DeGraffenried, M.D.
1208 Sunnymeade, DeKalb 60115

Jams H. Ryan, M.D.
401 North Wall, Kankakee 60901

STAFF: Larry N. Booth

COMMITTEE ON PUBLIC AFFAIRS

Council Members:

George T. Wilkins, *Chairman*
Robert Pierce
Non-Council members:
William Ashley
6545 West 33rd St., Berwyn 60402
Charles Downing
1067 W. Main, Decatur 62522
Theodore Grevas
1800 Third Ave., Rock Island 61201
Jerry Ingalls
502 Shaw, Paris 61944
Earl Klaren
158 E. Cook, Libertyville 60048
Frank J. Kresca
208 W. Green, Champaign 61820
W. Robert Malony
Carbondale Clinic, Carbondale 62901
George T. Mitchell
Marshall 62441
Donal D. O'Sullivan
203 Forest Ave., Oak Park
Elliott Partridge
1201 Pine St., Eldorado 62930
John L. Savage
723 Elm St., Winnetka 60093

Julius P. Schweitzer
120 Oakbrook Mall, Oakbrook 60521
P. John Seward
2623 Edgemont, Rokford 61103
Eugene H. Siegel
103 Haven Rd., Elmhurst 60126
V. P. Siegel
6600 W. Main, Belleville 62223
Herbert Sohn
4640 N. Marine Dr., Chicago 60640
A. E. Steer
701 N. Walnut, Springfield 62702
Frederick E. Weiss
15318 Center Ave., Harvey 60426
Lorin D. Whittaker
331 Fulton St., Peoria 61602
Joseph Hinkamp
429 Pine Manor, Wilmette

AUXILIARY REPRESENTATIVE:

Mrs. H. J. Failor
9 Litchfield Lane, Champaign, 61120

STAFF: Arvid Hammers

AD-HOC COMMITTEE on LEGAL DEFINITION OF DEATH 1972-1973

Jacob E. Reisch, *Chairman*
1129 S. 2nd St., Springfield 62704
Tom Baffes
Dept. of Surgery, Mt. Sinai Hospital
California Ave. at 15th St., Chicago 60608
Benjamin Boshes
251 East Chicago Ave., Chicago 60611
William Dye
3200 Highland, Downers Grove 60515

Edward Ference
932 S. 2nd, Springfield 62704

Victor Wojner
1503 West Charles, Champaign 61820

Fred Merkel
151 Sheridan Road, Kenilworth 60643

STAFF: Larry N. Booth

MEDICAL-LEGAL COUNCIL

Clinton L. Compere, *Chairman*
737 N. Michigan, Chicago 60611
David T. Petty, *Vice-Chairman*
30 N. Michigan, Chicago 60602
George Alvary
1110 N. Green, McHenry 60050
James Gladish
995 N. Main, Rockford 61103
Edward Grossman
4050 Morse Ave., Lincolnwood
James Habegger
(*Liaison with Pathology Soc.*)
32 S. Lincoln, Geneva 60134
Vincent Sarley (*IMT*)
682 Pine, Deerfield 60015
Donal O'Sullivan
203 Forest Ave., Oak Park 60302
Harold Sofield
715 Lake St., Oak Park 60301
Herman Wing
400 E. Randolph, Chicago 60601

CONSULTANTS:

Joseph L. Bordenave
1665 South St., Geneva 60134
Fredric Lake
2520 N. Lakeview, Chicago 60614
Allan Goslin
712 N. Bloomington, Streator 61634
A. Everett Joslyn
(Liaison with Insurance Comm.)
557 Keystone Ave., River Forest 60305
Frederick E. Weiss
15643 Lincoln, Harvey 60426

SAMA REPRESENTATIVES:

Gary Skaletsky, U. of I.
3865 W. Fargo, Skokie 60076
John Dowdle, Loyola University
5465 S. Everett, Chicago 60615

STAFF: H. Michael Wild

Responsibilities and Purposes:

The Medical Legal Council shall cooperate with all organizations interested in medico-legal problems in order to educate members of the profession in medico-legal affairs.

This council shall maintain liaison with the Illinois Bar Association and cooperate with the judiciary in both federal and state courts within the state of Illinois. It shall, when requested by the court, activate the Impartial Medical Testimony panel. The stated objective of the panel is to provide consultations, judgment and opinions in personal injury situations in which there is unusual controversy or wide divergence of medical opinion.

The council shall effect methods of elevating and maintaining the standards of medical laboratories in Illinois and encourage the use of medical diagnostic laboratories supervised by duly qualified physicians. In addition, the council shall be concerned with licensing and standards of practice and quackery.

Committee:

Arbitration

SUB-COMMITTEE ON ARBITRATION

Council Members:

Clinton L. Compere

George Alvary

Non-Council Members:

David T. Petty
30 N. Michigan, Chicago 60602
Vincent Sarley
682 Pine, Deerfield 60015
STAFF: H. Michael Wild

COUNCIL ON MENTAL HEALTH AND ADDICTION

Marshall A. Falk, *Chairman*
4700 N. Clarendon, Chicago 60640
Nathaniel S. Apter
111 N. Wabash, Chicago 60602
Irving Frank
135 S. Sacramento, Sycamore 60178
Abraham Gelperin (*Med. Supt.*) (*Alcoholism*)
Oak Forest Hospital, 159th & Cicero, Oak Forest
Walter P. Plassman
Box 552, Centralia 60901
Alex Spadoni
2301 Glenwood Ave., Joliet 60435
W. David Steed
10011 Lake St., Suite 423-4, Oak Park 60301
Donovan Wright
135 S. Kenilworth, Elmhurst 60126
Ronald Schlensky
251 E. Chicago, Suite 930, Chicago 60611
Howard D. Kurland
636 Church Street, Evanston 60201
Albert W. Ray
(*Liaison to Narcotic Groups*)
709 Terry Drive, Joliet 60435
S. Dale Loomis
700 N. Michigan Ave., Chicago 60611
Patrick Ebenhoeh
(*Liaison of IPS to ISMS*)
518 Echo Lane, Glenview 60026

CONSULTANTS:

Joseph H. Skom
707 N. Fairbanks Ct., Chicago 60611
Albert Glass, Director
Ill. Dept. of MH, 160 N. La Salle, Chicago

SAMA REPRESENTATIVES:

John Schaible, U. of I.
1640 W. Adams St., Chicago 60612
Bob Gilligan, Loyola
1922 S. 5th Ave., Maywood 60153

AUXILIARY REPRESENTATIVE:

Mrs. John (Mary) Koenig
2518 Oakwood Dr., Olympia Fields 60461

STAFF: Richard A. Ott

Responsibilities and Purposes:

This council shall serve as a source of information on mental health matters for ISMS, evaluate information and make recommendations to the Board of Trustees on positions ISMS should take on issues in this area, and cooperate with institutions, voluntary health agencies, state agencies and professional associations in disseminating information on mental health, alcoholism and drug abuse.

The council shall be on the alert for misleading or fallacious programs and information and recommend appropriate action. It shall also be concerned with reviewing legislation related to the field of mental health, alcoholism, drug abuse, and hazardous substances.

ISMS/IPS PEER REVIEW CONSULTING COMMITTEE

Council Members:
Alex Spadoni, *Chairman*
Marshall Falk
S. Dale Loomis
Donovan Wright

Non-Council Member:
LeRoy Levitt
Chicago Medical School
2020 W. Ogden Ave., Chicago 60612

STAFF: Richard A. Ott

COUNCIL ON PUBLIC RELATIONS AND MEMBERSHIP SERVICES

Lee F. Winkler, *Chairman*
850 South 4th Street, Springfield 62703

Paul J. Biedenharn
Medical Arts Bldg., New Baden 62265

Raymond H. Conley
1 North Dee Road, Park Ridge 60068

William F. Hensold
7 North Virginia St., Danville 61832

Charles W. Pfister (*Liaison w/Clergy*)
5511 North Harlem, Chicago 60656

Catherine L. Dobson
5842 Stony Island Ave., Chicago 60637

CONSULTANTS:

Fredric D. Lake
1041 Michigan Ave., Evanston 60202

Philip G. Thomsen
13826 Lincoln Ave., Dolton 60419

Charles J. Weigel
7579 Lake St., River Forest 60305

SAMA REPRESENTATIVES:

Connie Norgaard, U. of I.
846 S. Loomis St., #3R, Chicago 60607
Paul J. Hering, Loyola
2040 S. 16th St., Broadview 60153

AUXILIARY REPRESENTATIVE:

Mrs. Clement P. Cunningham
2921 - 27th Street, Rock Island 61201

STAFF: Robert L. Zimmerman

Responsibilities and Purposes:

The Council on Public Relations and Membership Services shall plan and execute programs designed to enhance the relationship between the media, clergy, genral public and medical profession. Included shall be health education and socio-economic programs believed to be in the best interest of the profession as well as the general public. The Council shall be responsible for membership recruitment, new member orientation, exhibits and public service programming.

Committee:

Membership Procurement and Retention, *ad hoc*

COUNCIL ON SOCIAL & MEDICAL SERVICES

Thomas R. Harwood, *Chairman*
333 E. Huron, Chicago 60611
Julian W. Buser
6600 W. Main St., Belleville 62223
Carl E. Clark
225 Edward St., Sycamore 60178
Matthew B. Eisele (*Comm. on Emergency Med. Services*)
3 Kilmar Woods, Belleville 62223
Kenneth A. Hurst
157 S. Lincoln, Aurora 60505
Max Klinghoffer
127 E. Vallette, Elmhurst 60126
James C. Reid
712 S. College, Greenfield 62044
Joel S. Rosen (*Liaison w/DVR & physiatrists*)
401 E. Ohio St., Chicago 60611
Aaron M. Rosenthal
4700 N. Clarenden, Chicago 60640
Paul G. Theobald
1210 Towanda Plaza, Bloomington 61801
Thomas T. Tourlentes
2701 - 17th St., Rock Island 61201

CONSULTANT:

Paul W. Sunderland
214 N. Sangamon, Gibson City 60419

SAMA REPRESENTATIVES:

Oliver Crawford, U. of I.
906 S. Bishop, 3F Chicago 60615
Robert J. Herfkins, Loyola
1137 S. East Ave., Oak Park

STAFF: Robert L. Zimmerman

Responsibilities and Purposes:

The Council on Social and Medical Services shall initiate and implement programs related to health care facilities, hospital services, emergency room and disaster medical care; maintain liaison with the nursing profes-

sion and other health-oriented organizations, including the Illinois Department of Vocational Rehabilitation; handle problems related to aging, rural health and health care of the poor.

Committees:
Aging, *ad hoc*
Rehabilitation Services, *ad hoc*
Emergency and Disaster, *ad hoc*

COMMITTEE ON AGING

Council Members:
Thomas T. Tourlentes, *Chairman*
Julian W. Buser
Kenneth A. Hurst
Non-Council Members:
John W. Bowden
330 Madison, Joliet 60435
Bertram B. Moss
Park View Home, 1401 N. California, Chicago 60622

STAFF: Robert L. Zimmerman

Responsibilities and Purposes:

The Committee on Aging shall consider matters related to the broad field of aging, including socio-economic as well as medical services. The committee shall maintain liaison with other agencies having a similar interest, including the American Medical Association's Committee on Aging.

COMMITTEE ON REHABILITATION SERVICES

Council Members:
Joel S. Rosen, *Chairman*
Aaron M. Rosenthal
James C. Reid

STAFF: Robert L. Zimmerman

Responsibilities and Purposes

The Committee on Rehabilitation Services shall assist public and private agencies in the establishment of policies regarding rehabilitation facilities and services; including training and quality and type of services available. The committee also works closely with the Governor's Committee on Employment of the Handicapped.

Committees of the Board of Trustees

COMMITTEE ON CONSTITUTION & BYLAWS

Fredric D. Lake, *Chairman*
1041 Michigan Avenue, Evanston 60202
Herbert Dexheimer
301 S. Illinois, Belleville 62220
Allan L. Goslin
712 N. Bloomington, Streator 61364
A. Edward Livingston,
219 N. Main St., Bloomington 61701
Warren Tuttle
293 N. Vine St., Harrisburg 62946
CONSULTANTS:
James Fletcher
Paul W. Sunderland
STAFF: Perry Smithers

Responsibilities and Purposes:

The Committee on Constitution & Bylaws shall:

1) Receive from individual members, county societies, committees, the Board of Trustees and the House of Delegates, all suggestions and proposals for modification of the Constitution & Bylaws;

2) Prepare for the consideration of the House of Delegates, all changes in the Constitution & Bylaws; and

3) Maintain constant surveillance of both documents to keep them current, effective and consistent with the policies of the House of Delegates.

The Speaker of the House of Delegates shall be an ex-officio member of this committee.

COMMITTEE ON COMMITTEES

Allan L. Goslin, *Chairman*
712 Bloomington, Streator 61364
George Shropshear
1525 E. 53rd St., Chicago 60615
Philip G. Thomsen
13826 Lincoln Ave., Dolton 60419
STAFF: Perry Smithers

Responsibilities and Purposes:

The Committee on Committees shall consist of three members of the Board appointed by the chairman. It shall serve to review the purposes, activities and structure of any councils or committees at the request of the Board.

The committee shall recommend such changes in existing councils or committees as required to maintain the efficient operation of the affairs of the Society.

The activities and reports of the Committee on Committees shall be reviewed by the Executive Committee and approved by the Board of Trustees.

ETHICAL RELATIONS COMMITTEE

Paul Sunderland, *Chairman*
214 N. Sangamon, Gibson City 60936
Joseph Skom
707 Fairbanks Ct., Chicago 60611
Joseph O'Donnell
444 Park, Glen Ellyn 60137
Arthur Goodyear
142 East Prairie, Decatur 62523
STAFF: Roger N. White

Responsibilities and Purposes

The responsibilities and purposes of this committee are outlined in CHAPTER XI. DISCIPLINE, Part 2 *Illinois State Medical Society Procedures.*

Section 1. Illinois State Medical Society Ethical Relations Committee. The Board of Trustees shall appoint from its members an Ethical Relations Committee to review decisions of the component society involving the interpretation of the Principles of Medical Ethics, violations of the Constitution and By-laws of the Illinois State Medical Society or its component societies and charges of misconduct of members of the Society.

Section 2. Appeals from Component Society Verdicts. Appeals received by the Illinois State Medical Society Board of Trustees shall be referred to the Ethical Relations Committee of the Board of review. (Appeals must be accompanied by a comprehensive stenographic record of the proceedings taken before the component county society together with all exhibits submitted in evidence. If the component county society fails to provide the record on appeal, the Ethical Relations Committee of Illinois State Medical Society shall find the accused "not guilty.") The committee shall notify the accused and the secretary of the component society by certified mail at least thirty days prior to the date set for hearing of the appeal. The chairman of the committee shall preside over the hearing in accordance with the rules established by the Board of Trustees.

Section 3. Verdict. The Ethical Relations Committee of the Board of Trustees shall hear any new and pertinent evidence any interested party desires to present, and at the conclusion of the trial, the decision of the component society shall be affirmed, overruled or sent back to the component society for reconsideration.

Section 4. Notification and right of appeal. The secretary of the Society shall notify the defendant and the secretary of the component society wherein the defendant holds membership, of the action of the Board. In the event of a decision against the accused he shall have the right to appeal the decision to the Judicial Council of the American Medical Association and the secretary of the State Society shall so notify the accused of this right.

EXECUTIVE COMMITTEE

William M. Lees, *Chairman*
6518 North Nokomis, Lincolnwood 60646
Frank J. Jirka, Jr.
1507 Keystone Ave., River Forest, 60305
Willard C. Scrivner
Suite #2, 6600 West Main, Belleville 62223
Mather Pfeiffenberger
State and Wall Sts., Alton 62002
Joseph L. Bordenave
1665 South St., Geneva 60134
Jacob E. Reisch
1129 S. 2nd St., Springfield 62704
Charles J. Jannings III
101 East Center, Fairfield 62837
EX-OFFICIO
Paul W. Sunderland
214 N. Sangamon St., Gibson City 60936
STAFF: Roger N. White

Responsibilities and Purposes

The Executive Committee shall consist of the president, the president-elect, the chairman of the Board, the chairman of the Finance Committee, the chairman of the Policy Committee, the secretary-treasurer, the trustee-at-large and the immediate past chairman of the Board provided he is still a Trustee.

It may be given authority to act by the Board of Trustees.

In matters of routine administration, special plans, policy, endorsement or expenditure it shall report to and request approval of the Board. It shall receive the reports of the Finance and Policy Committees and make recommendations concerning them to the Board. It shall furnish a report of its actions to the Board at each meeting.

By laws. Chapter IX, Part 4, Section 2. Paragraph A.

FINANCE COMMITTEE AND MEDICAL BENEVOLENCE

Mather Pfeiffenberger, *Chairman*
State & Wall Streets, Alton 62002
Jacob E. Reisch
1129 South 2nd Street, Springfield 62704
Robert Fox
2136 Robin Crest, Glenview 60025
Fred Z. White
723 North Second Street, Chillicothe 61523
STAFF:
Roger N. White
Richard D. Hengl

Responsibilities and Purposes

The Committee shall consist of the secretary-treasurer of the Society and three members of the Board appointed by the chairman. It shall develop a budget for the fiscal year for approval of the Board through the Executive Committee. It shall supervise the financial transactions of the Society. It shall make recommendations to the Board for the control and investment of the funds of the Illinois State Medical Society.

The Finance Committee shall also be responsible for the society's Medical Benevolence Program and shall:

1. Examine applications for financial assistance and determine eligibility.

2. Keep the names of the beneficiaries confidential and known only to the committee.

3. Determine the allotment for each recipient.

4. If funds available become inadequate to meet disbursements, request the Board of Trustees to appropriate sufficient funds to support the program until the next budget appropriation.

POLICY COMMITTEE

Joseph L. Bordenave, *Chairman*
1665 South St., Geneva 60134
Andrew J. Brislen
6060 Drexel Ave., Chicago 60637
David S. Fox
20829 Greenwood Center Ct., Olympia Fields 60461
STAFF: Perry Smithers

Responsibilities and Purposes

The Policy Committee shall consist of three members of the Board appointed by the chairman. It shall continually review past and current proceedings of the House of Delegates to determine the established policies of the Illinois State Medical Society. It shall make recommendations for future policy by Board resolution to the House of Delegates.

PUBLICATIONS COMMITTEE

Jacob E. Reisch, *Chairman*
1129 South Second St., Springfield 62704
Warren W. Young
3450 Haweswood Dr., Crete 60417
Eugene T. Hoban
6429 North Ave., Oak Park 60302
Glen Tomlinson
Fantus Clinic, Cook Co. Hosp.,
1825 W. Harrison, Chicago 60612
Frederick E. Weiss
15643 Lincoln, Harvey 60426
STAFF: Richard A. Ott

Responsibilities and Purposes

The Publications Committee shall be composed of five members of the Board of Trustees, and shall be responsible for the production of the *Illinois Medical Journal* and other Society Publications.

It shall recommend to the Board of Trustees all policies governing the editorial, business and production aspects of the *Journal*. It shall supervise the editor in the selection and preparation of all copy, and it shall establish standards for the editorial content.

It shall establish advertising policies, rates, and standards, and shall review all new accounts prior to acceptance, and shall approve reprint and circulation policies.

It shall conduct a periodic review of the printer's contract and solicit bids as indicated. It shall establish the format, cover, type faces and general layout of the Journal.

The committee may establish such editorial consultation groups as necessary to assist in development of clinical articles and shall authorize all regular and special features.

ADVISORY COMMITTEE TO THE WOMAN'S AUXILIARY

Willard C. Scrivner, *Chairman*
Suite #2, 6600 W. Main, Belleville 62223
Frank J. Jirka, Jr.
1507 Keystone, River Forest 60305
William M. Lees
6518 N. Nokomis, Lincolnwood 60646
STAFF: Roger N. White

Responsibilities and Purposes

The committee shall consist of the president-elect as chairman, the president, the chairman of the Board. The committee shall provide advice and assistance to the president of the Woman's Auxiliary in her program for the year, and shall assist her in interpreting the activities of the state medical society to the auxiliary members.

Free Standing Committees

All Board Committees previously noted consist of members of the Board of Trustees. As such they function within the activities of the Board.

Free Standing Committees are groups deemed necessary by the Board of Trustees and are created by the Board on an ad hoc basis to meet specific challenges. These committees may function with, and under, a council, or may report directly to the Board of Trustees.

While other select committees will be formed from time to time, at the time of publication the following groups had been established.

Annual Meeting Joint Management Committee

William E. Adams, *Chairman*
55 E. Erie, Chicago
Joseph Bordenave
1665 South Street, Geneva 60134
Andrew J. Brislen
6060 W. Drexel Blvd., Chicago 60637
Jacob E. Reisch
1129 S. Second St., Springfield 62704
Harold A. Sofield
715 Lake St., Oak Park 60301
Paul W. Sunderland
214 W. Sangamon St., Gibson City 60936
Fred A. Tworoger
4753 Broadway, Chicago
Fred Z. White
723 N. Second St., Chillicothe 61523

STAFF: Perry Smithers

Responsibilities and Purposes:

The committee, consisting of equal numbers of representatives of the Illinois State Medical Society and the Chicago Medical Society, is responsible for the overall management of the Midwest Clinical Conference, which is co-sponsored annually by the two organizations, in cooperation with various medical specialty groups. This committee establishes broad policy for the convention, including the setting of dates and place for the meeting, decides on the general format of the problem, delineates the areas of responsibility for the major co-sponsoring organizations, and oversees the budget for the conference.

COMMITTEE ON DRUGS AND THERAPEUTICS

Robert C. Muehrcke, *Chairman*
518 North Austin Blvd., Oak Park 60302
Joseph D. Cece, Jr.
120 Oakbrook, Oak Brook 60521
Charles R. Frazer, Jr.
1401 Gaty Ave., East St. Louis 62201
Richard L. Landau
950 E. 59th St., Chicago 60637
William H. Walton
109 S. High St., Belleville 62220
Andrew Krajec
108 W. South Street, West Salem 62476
Arthur Marks
101 E. Center St., Fairfield 62837

CONSULTANTS:

Louis Gdalman, R.Ph.
5418 S. East View Park, Chicago 60615
Bruce Flashner
Illinois Department of Public Aid, Medical Director
209 W. Jackson Blvd. - Room 602, Chicago 60606
Richard Suhs
1409 Stevenson Dr., Springfield 62703

STAFF: Mrs. Pat Uznanski

Responsibilities and Purposes:

The Committee shall meet periodically to refine the drug list contained in the Drug Manual. It shall work with the Illinois Department of Public Aid in an effort to keep the Drug Manual current and effective. When suggestions and comments from the members are submitted to the committee, it shall review them and present them to the Department of Public Aid when necessary. The committee shall also consider other drug matters affecting the policy of the medical society.

COMMITTEE ON INSURANCE

Lawrence Knox, *Chairman*
1200 N. East St., Olney 62450
Philip D. Boren
S. Plum St., Carmi 62821
Martin Compton
3003 East Oakland Ave., Bloomington 61701
Theodore LeBoy
917 Norwood Dr., Melrose Park 60160
A. Everett Joslyn
557 Keystone Ave., River Forest 60305

CONSULTANTS:

A. Edward Livingston
219 North Main, Bloomington 61701
Jacob E. Reisch
1129 South 2nd St., Springfield 62704
Fred Z. White
723 North 2nd St., Chillicothe 61523

STAFF: Perry Smithers

Responsibilities and Purposes:

The Committee on Insurance will review society-sponsored insurance programs, which are currently the Tax Qualified Retirement Program (Keogh Plan), Retirement Investment Program, Group Disability Program, Group Major Medical Program, Hospital Income Program, Group Life Insurance and Professional Liability Insurance Program. The committee will study these plans, make suggestions for changes, additions and cancellation of policies, and investigate other insurance programs that may benefit society members.

SPECIAL LIAISON COMMITTEE to ILLINOIS DEPARTMENT OF MENTAL HEALTH

John Ovitz, *Chairman*
204 W. Elm St., Sycamore 60178
LeRoy Levitt
2020 W. Ogden Ave., Chicago 60612
Morgan Meyer
815 S. Main, Lombard 60148

STAFF: Richard A. Ott

Responsibilities and Purposes:

To work in conjunction with the Department of Mental Health to develop education programs and cooperation between institutions and county medical societies.

REPRESENTATIVES TO STUDENT LOAN FUND BOARD

Donald Stehr, *Chairman*
102 E. Market, Havana 62644
Jack Gibbs
175 S. Main St., Canton 61520
Charles Salesman
1 Laurel Lane, Paris 61944
CONSULTANT:
Jacob E. Reisch
1129 S. 2nd St., Springfield 62704
STAFF: Perry L. Smithers

Purpose:

ISMS representatives on the Student Loan Fund Board are responsible to the Board of Trustees in matters related to administration of the Student Loan Program operated jointly with the Illinois Agricultural Association.

COMMITTEE TO STUDY CERTIFICATE OF NEED LEGISLATION (HB 2653)

Frank J. Jirka, Jr. *Chairman*
1507 Keystone, River Forest 60305
Alfred Faber
2100 Swainwood Dr., Glenview 60025
Joseph O'Donnell
444 Park Blvd., Glen Ellyn 60137
William M. Lees
6518 N. Nokomis, Lincolnwood 60646
J. Ernest Breed
55 E. Washington, Chicago 60602

STAFF: Roger N. White

PLANNING AND PRIORITIES COMMITTEE

Willard C. Scrivner, *Chairman*
Suite 2, 6600 W. Main, Belleville 62223
Frank J. Jirka, Jr.
1507 Keystone, River Forest 60305
Philip G. Thomsen
13826 Lincoln, Dolton 60419
William M. Lees
6518 N. Nokomis, Lincolnwood 60646
Alfred W. Faber
2100 Swainwood Drive, Glenview 60025

STAFF:

Roger N. White
J. Bernie Robinson

COMMITTEE ON HOSPITAL MANPOWER

Frank J. Jirka, Jr., *Chairman*
1507 Keystone, River Forest 60305

Joseph Bordenave
1665 South St., Geneva 60134

Jack Gibbs
175 Main St., Canton 61520
Julian Buser
6600 W. Main, Suite 8, Belleville 62223
Kenneth Schnepp
725 S. 2nd St., Springfield 62702
Ross Hutchison
126 E. 9th St., Gibson City 60936

STAFF: Philip G. Thomsen, II

Other Appointments and Representatives

The Board of Directors of the Educational and Scientific Foundation, and representatives to other organizations, report directly to the Board of Trustees periodically as necessary.

EDUCATIONAL AND SCIENTIFIC FOUNDATION

C. J. Jannings, III, *Chairman*
101 E. Center, Fairfield 62837
Frank J. Jirka, Jr.
1507 Keystone Ave., River Forest 60315
Willard C. Scrivner
6600 W. Main St., Belleville 62223
William M. Lees
6518 N. Nokomis, Lincolnwood 60646
Jacob E. Reisch
1129 S. Second St., Springfield 62704

STAFF: Perry Smithers

Responsibilities and Purposes

The foundation was founded to provide an administrative agency to foster the advancement of medical science through (1) the initiation of scientific and medical research activities, (2) the collection, evaluation and dissemination of the results of research activities to the public and (3) the implementation and management of projects related to medicine for individuals or organizations seeking to inform or educate others, or to improve their own knowledge. The charter of the foundation calls for a board of directors consisting of the following officers of the Illinois State Medical Society: Immediate Past President (as chairman), Chairman of the Board of Trustees, President, President-elect, and Secretary-Treasurer.

ILLINOIS COUNCIL on CONTINUING MEDICAL EDUCATION
Board of Directors

Richard Byyny, *Chairman*
Pritzker School of Medicine, University of Chicago
950 E. 59th St., Chicago 60637

Dean Bordeaux
2421 W. Rohmann Ave., Peoria 61604

Eli Borkon
Box 1030, Carbondale 62901

J. Ernest Breed
55 E. Washington St., Chicago 60602

Herschel Browns
460 N. Ravenswood Ave., Chicago 60640

Joel Brumlik
Stritch School of Medicine, Loyola University
2160 S. First Ave., Maywood 60153

Edward W. Cannady
6600 W. Main St., Belleville 62223

Willard G. DeYoung
11613 S. Longwood Dr., Chicago 60643

Robert T. Fox
2136 Robin Crest Lane, Glenview 60025

Jack L. Gibbs
175 S. Main St., Canton 61520

John Graettinger
Rush Medical College, 1725 W. Harrison St.,
Chicago 60612

R. A. Kistner
Chicago College of Osteopathic Medicine,
1122 E. 53rd St., Chicago 60615

LeRoy P. Levitt
Chicago Medical School
2020 W. Ogden Ave., Chicago 60612

George E. Miller
Center for Educational Development,
University of Illinois, Chicago 60612

Mather Pfeiffenberger
State & Wall St., Alton 62002

George Shropshear
1525 E. 53rd St., Chicago 60615

Jacob E. Suker
Northwestern University Medical School,
303 E. Chicago Ave., Chicago 60611

EXECUTIVE DIRECTOR: Leonard Stein, Ph.D.

Responsibilities and Purposes

The Illinois Council on Continuing Medical Education is an independent statewide not-for-profit corporation organized to develop and coordinate continuing education activities for Illinois physicians. Its Board of Directors consists of representatives of each medical school in Illinois and a matching number of physicians appointed by the Illinois State Medical Society plus a society member who also serves on the Council of Education and Manpower.

OTHER REPRESENTATIVES

SWANBERG FOUNDATION, QUINCY
Arkell M. Vaughn, 9012 S. Leavitt, Chicago 60620

HEALTH CAREERS COUNCIL OF ILLINOIS (HCCI)
Eugene P. Johnson, 22 West Main St., Casey 62420 (HCCI Board)
Allison Burdick, Jr., 5906 West North Avenue, Chicago 60639 (HCCI Board)
Casper Epsteen, 25 East Washington, Chicago 60602 (Del. HCCI Senate)
Carl E. Clark, 225 Edward, Sycamore 60178 (Del. HCCI Senate)

MIDWEST REGIONAL LIBRARY ASSOCIATION
William E. Adams, 55 E. Erie St., Chicago 60611

LIAISON TO ILLINOIS SOCIETY OF THE AMERICAN ASSOCIATION OF MEDICAL ASSISTANTS
Carl E. Clark, 225 Edward St., Sycamore 60178

ILLINOIS COUNCIL OF HOME HEALTH AGENCIES
Edward W. Cannady, 4601 State Street, E. St. Louis 62205

ISMS SERVICES

Pursuit of Obligations

PURPOSES OF THE ILLINOIS STATE MEDICAL SOCIETY ARE:

- to promote the science and art of medicine
- to protect the public health
- to evaluate standards of medical education
- to unite the medical profession behind these purposes
- to unite with similar organizations in other states and territories of the United States to form the American Medical Association.

The Society shall inform the public and the profession concerning the advancements in medical science and the advantages of proper medical care.

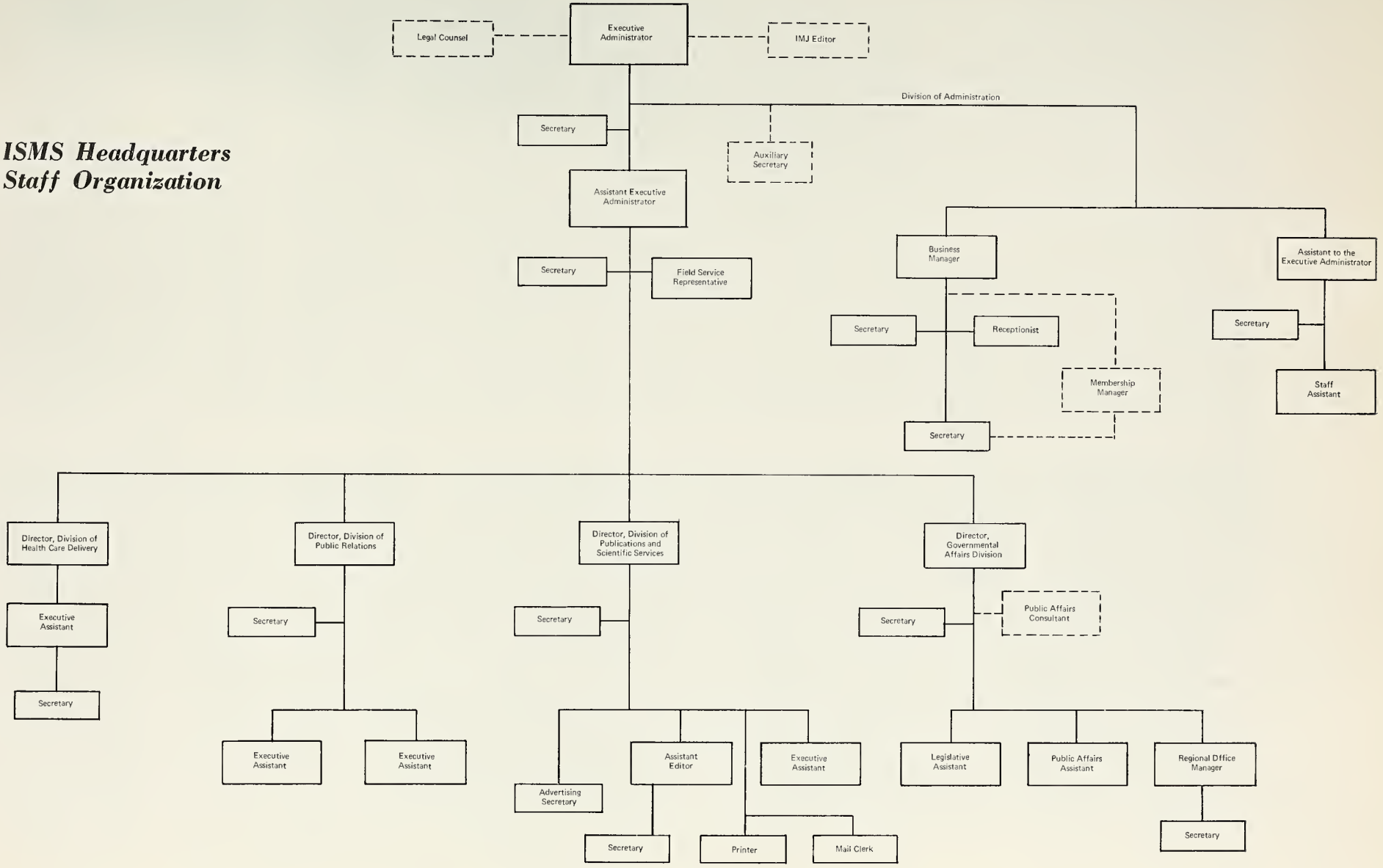
To fulfill these purposes, the Society maintains a headquarters office at 360 N. Michigan Ave., Chicago, and an office in Springfield at 520 S. Sixth St. Services of the Society, under the general supervision of Roger N. White, Executive Administrator, are conducted by the following divisions:

Administration; Public Relations and Membership Services; Governmental Affairs; Publications and Scientific Services; and Health Care Delivery.

Many and varied are the activities of the Society in pursuit of its obligations. Some of these activities are major programs of statewide (and sometimes national) interest for all citizens; others are of special interest to doctors; still others are sponsored for specific groups or individuals.

Following are general descriptions of the Society's divisions and the programs, services and publications available directly to Society members or sponsored for their benefit.

ISMS Headquarters Staff Organization



DIVISION OF ADMINISTRATION

The Executive Administrator has the responsibility and the authority to provide for the smooth and efficient functioning of the Illinois State Medical Society.

The implementation of established policy, fiscal and budgetary matters, the employment of qualified personnel and the development and maintenance of personnel policies are all part of the Administrator's activities.

He maintains liaison with the Board of Trustees and assists the chairman in carrying out his duties. Close cooperation with the speaker of the House of Delegates and the officers of the Society provides a smooth and efficient atmosphere in which the Society may function. Cooperation is maintained with the Committee on Constitution and Bylaws to present to the House all suggested changes for official action. The Administrator channels all legal inquiries and works with the General Legal Counsel to provide guidance to the officers, trustees, committee chairmen and county medical society officers.

To provide the membership of the Society with the best professional staff services available, headquarters has been set up by divisions.

The Assistant Executive Administrator serves within this Division as a coordinator for the programs operated by other Divisions. Further coordination between the programs of the State Society and the County Medical Societies is achieved through a Field Services Representative working under the direction of the Assistant Executive Administrator.

The Society sponsored insurance programs, benevolence programs, travel tours for members, physician placement programs, student loan fund program and all activities concerning the annual meeting are handled within the Division by the Assistant to the Executive Administrator.

The accounting and business service functions of the Society are handled by the Business Manager as a part of this Division. The Division also maintains the membership records and provides a computerized central dues billing and collection center for county medical societies. The Society's accounting and membership records are handled in close coordination with the Secretary-Treasurer under policies laid down by the Finance Committee and the Board of Trustees.

GOVERNMENTAL AFFAIRS DIVISION

As professional medicine strives to maintain the vigorous condition of the public health, the profession is vitally and intimately concerned with legislative actions of the Illinois General Assembly and the U. S. Congress which affect physicians, other members of the healing arts, and the lay public. To insure that the best health interests of the public and professional interests of the physician are served, the Division monitors all state and national legislation which affect the health of the individual and his community.

The monitoring process is designed to present the thoughtful views of professional medicine in Illinois on specific medically related pieces of legislation.

The ISMS Governmental Affairs Council acts as the clearing house for legislative proposals recommended by specialized ISMS committees; generated by allied groups; produced by special interests and introduced by representatives and senators. Such legislation is thoroughly analyzed by physician-members of the specialized ISMS committee covering the subject matter of the introduced legislation.

Support or Oppose Legislation

Upon appropriate consideration and recommendation, legislation of medical significance in the Illinois Legislature is either supported or opposed to protect and promote the interests of the public and the profession. Pertinent subject matter testimony is presented before the House and Senate committees as the bill proceeds through the legislative process.

On-the-scene surveillance of monitored legislation is maintained by ISMS legislative representatives.

Through these essential actions, ISMS plays a meaningful role in shaping legislation for the betterment of the people of Illinois.

Action similar to the above is taken with respect to bills in Congress when they have special significance to Illinois physicians. This activity is conducted in concert with the American Medical Association.

Integrated with and designed to augment the legislative activity is the Public Affairs Program. The ISMS Public Affairs Committee strives to alert the physician to his role in public affairs and to involve him in effective participation in public affairs in his community, state, and nation.

Other Activities

The division also staffs the committees on Eye Health, Forensic Medicine, and Definition of Death.

DIVISION OF HEALTH CARE DELIVERY

The Division of Health Care Delivery, formerly a part of the Public Relations Division, was given its present status because of the many important and complex socio-economic issues currently facing medicine.

A primary responsibility is to keep ISMS members abreast of these socio-economic issues which have such impact on the delivery of health care. The division hopes to expand its activities in researching the many new types of health care programs being proposed throughout the state. This pertinent socio-economic information will be disseminated to ISMS members through articles in the *Illinois Medical Journal* and "Action Report," and through conducted programs.

Another responsibility of the Division of Health Care

Delivery is to work closely with the Illinois Foundation for Medical Care and to serve as liaison between ISMS and IFMC. In addition, the division staffs the Committee on Governmental Health Program Reimbursement which serves as ISMS liaison to Medicare, Medicaid and CHAMPUS. Representatives of these programs meet regularly with the committee to discuss problems and work out solutions.

The Council on Economics and Peer Review is also included in this division. Principle duties of the Council concern relations with the health insurance industry and health care planning programs, such as Comprehensive Health Planning and the Illinois Regional Medical Program.

A second responsibility of the council is to encourage the establishment of peer review mechanisms by county medical societies. The council, through its Peer Review Appeals Committee, also serves as the appellate body for all disputed cases initially considered by local or district peer review committees.

Finally, the Division of Health Care Delivery staffs the Illinois Department of Public Aid Medical Advisory Committee as an observer, and the Illinois Regional Medical Program's Task Force on Health Information.

DIVISION OF PUBLIC RELATIONS and MEMBERSHIP SERVICES

The Division of Public Relations functions both as a news outlet to the media and as a source of information to the membership.

Staff members prepare speeches and produce pamphlets and other materials on a wide variety of medical topics. They serve as consultants on public relations and publicity to county societies; and also maintain liaison with state and private agencies in the health field and with allied associations.

The division is contacted almost daily by medical and scientific news writers who are obligated to provide timely information to a public that is increasingly interested in the many phases of health care.

The proliferation in recent years of health agencies at every level of government has brought the additional staff duty of "keeping up" with the activities of these agencies and reporting to the membership.

Beyond these traditional public relations duties, the division has initiated a number of special and highly successful projects. A few of them are:

Journalism Awards . . . are given annually for "distinguished achievement in medical journalism" in a variety of categories covering all media. The presentation program is thoroughly professional and the winners value the awards as a sincere recognition of their own efforts to inform the public.

President's Tour . . . takes the president of ISMS to each of the 11 Districts and gives him a chance to meet and discuss medical matters with physicians throughout the state. The president also holds press conferences and visits local media for interviews during the tour.

Action Report . . . is a twice-monthly publication which keeps members informed of current developments on such vital issues as malpractice problems. The report also covers legislative and socio-economic events affecting the livelihood of all physicians.

Dr. SIMS Health Tips . . . provide Illinois newspapers and radio stations with a series of health tips for use six days a week, for all year. "Dr. SIMS Talks to Teens . . ." is a monthly column on health advice printed in more than 400 high school newspapers.

Radio-TV Speakers Bureau . . . obtains physician speakers for discussion of general medical subjects, or for special interviews on critical issues of the day.

Legislator TV Interviews . . . supplies the state's TV stations during sessions of the General Assembly with sound-on-film segments of the views of legislators on pending health bills. This accomplishes the triple purpose of publicizing ISMS; establishing contacts with key TV station personnel; and maintaining good relationships with the legislators involved.

DIVISION OF PUBLICATIONS AND SCIENTIFIC SERVICES

The Division of Publications and Scientific Services is charged with staff responsibility for a variety of activities. This is evidenced by Council and Committee assignments, to wit: Council on Education and Manpower, Council on Environmental and Community Health, Council on Mental Health and Addiction, Medical Legal Council, and the Publications Committee. Under the councils listed above are select committees and sub-committees. In addition, liaison is maintained with many public and voluntary organizations, on a formal basis, in order to keep abreast of current developments and to ensure representation of the Illinois State Medical Society.

Publications

Total production of all printed materials and publications, as well as their distribution, is this division's responsibility, except for distribution of items to selected specific groups. All printing and duplicating services are furnished either through an in-plant shop or outside services through competitive bidding. Modern reproduction and collating equipment allows for profes sional, commercial-quality production.

In addition, all mail room services are provided by this division. An addressograph and graphotype are utilized as well as a small wing mailer, folder and stuffer, and plate burning cabinets. Mailings are accomplished through computer-supplied labels and the addressograph.

Principal among the publications of the society is the official organ, the *Illinois Medical Journal*. The *Journal* is mailed monthly to all members, as well as other selected individuals, who are urged to read it to keep abreast of the scientific, economic, political, legal and social developments within the state, as such pertain to the practice of medicine. The editor welcomes suggestions for articles which may be of special interest to the membership. All members should consider the *IMJ* a means of communicating with fellow Illinois practitioners.

Special publications, brochures, flyers, pamphlets, letters and cards as required by the several ISMS divisions to carry forth their mission, are produced.

Advertising

Commercial advertising is carried within the *Illinois Medical Journal*. The maintenance of the records of advertisers, insertion orders, contracts, and direct communication and liaison with advertising agencies and pharmaceutical houses fall within the purview of the division. These are accomplished through an advertising department and ISMS representatives. This furnishes opportunity of presenting a product to members of ISMS through advertising in ISMS publications.

Educational and Scientific Services

As is apparent from the list of councils of ISMS for which staff responsibility is assigned, there is a multiplicity of activity. Liaison is maintained with many governmental and voluntary agencies to guarantee an awareness of current activities and to have medicine's voice heard. An ongoing scheduling of meetings of ISMS' committees provides opportunity for addressing the many concerns of medical practice today. The division, in addition, attempts to have expert information available to the members.

Needs of groups affiliated with or ancillary to ISMS, insofar as reproduction or distribution services are concerned, are also handled through the division office.

FILM

Modern Management of Multiple Births

"Modern Management of Multiple Births" is a 16 mm. sound-color motion picture produced by the Educational and Scientific Foundation of the Illinois State Medical Society in cooperation with Lederle Laboratories Division of American Cyanamid Co.

Teaching "heart" of the film is step-by-step reconstruction of an elaborate protocol which serves as a standard of prenatal planning for any physician faced with the management of multiple pregnancy.

For added teaching interest, the film reviews birth of identical quadruplets, showing how identicality was established with major and minor blood typings, examination of placenta and fetal membranes and other procedures. There are also scenes of actual delivery of quadruplets.

Showings of the film are restricted to professional audiences. Organizations may borrow the film from Lederle Laboratories Film Library, Pearl River, N. Y., or from the Illinois State Medical Society, 360 N. Michigan Ave., Chicago 60601.

SPECIAL PUBLICATIONS

Action Report

"Action Report" is a bi-weekly newsletter published by the Illinois State Medical Society. It is distributed to the doctors upon request. Purpose of the report is to alert physicians to important events or activities affecting practice of medicine.

A short deadline ensures that important news is disseminated to the physicians as quickly as possible so that appropriate responses may be made by ISMS.

On the Legislative Scene

Emanating from the Springfield Regional Office is a weekly newsletter, "On the Legislative Scene," published during the weeks the General Assembly is in session.

This is produced by the Governmental Affairs Division and distributed upon request to the select list developed for "Action Report." It includes up-to-the-minute status reports on pending legislation of vital concern to medicine in Illinois. This well-received periodical has permitted immediate response by ISMS representatives in Springfield to specific bills and has alerted physicians to the need for involvement in public affairs.

Comb-1 Insurance Form

Because of the variety of data required for health insurance claims, the Comb-1 Form was developed jointly by the American Medical Association and the Health Insurance Council to simplify and reduce the number of attending physician forms equally acceptable to the health insurance industry and the medical profession.

Information requested by many diverse forms from a large number of insurance companies was first classified and minimum needs for claim purposes were determined. Then appropriate and clearly worded questions were developed and arranged in a standard sequence, to facilitate completion. Out of this came two basic forms, one for group health insurance and one for individual health insurance, and four abbreviated forms. A further simplification involved devising an all-purpose form which is a combination of the group and individual forms—the Comb-1 Simplified Health Insurance Claim Form.

These forms are available to physicians from the Illinois State Medical Society and should be substituted for any non-standardized forms received. Each physician has been asked to voluntarily adopt the following procedure:

1) When a physician receives a form from an insurance company bearing the HIC symbol it should be completed and returned to the company.

2) When a physician receives a form *not* identified by the HIC symbol, the standardized form should be filled out and clipped to the unacceptable form with both forms returned to the insurance company.

3) If the insurance company insists upon having its own form completed, the doctor should feel justified in making a reasonable charge for the added work involved in handling the non-standardized form.

The attempt to standardize these forms is an aid in cutting back on the ever-increasing load of paper work involved in medical practice. Forms are available without charge from the ISMS Division of Public Relations.

Hospital Disaster Manual

The responsibility of providing immediate medical and hospital care in disasters of any magnitude falls directly on physicians, nurses and hospitals. To aid Illinois communities in developing disaster plans, the ISMS Committee on Public Safety adopted a model plan for hospitals.

Originally developed by the Memorial Hospital of DuPage County, Elmhurst, the plan is recognized as a model by the Office of Defense Mobilization in Washington, D. C. Copies are available from the Society.

Medical Career Recruitment Programs

As man has advanced his life expectancy, it follows that many additional young men and women are and will be needed as members of the health team. Youth must be counseled early in their academic years in order to receive the proper educational background for a doctorate of medicine or allied health field degree.

The Woman's Auxiliary of the ISMS has been the spearhead force in Illinois to interest and recruit the youth of the state in medical careers. Members are asked to aid this effort by investigating the possibility of conducting or participating in career days in their home communities.

A paperback book entitled "Horizons Unlimited" is available from the Society.

Oral Contraceptive Forms

Legal consent forms for use when dispensing birth control pills are now available to ISMS members. ISMS Trustees asked that the forms be prepared and made available because of adverse court decisions against physicians prescribing the pill.

Use of the consent forms is optional with each physician.

SCIENTIFIC SPEAKERS BUREAU

The Illinois State Medical Society, through its Scientific Speakers Bureau, aids county societies in their efforts to keep members abreast of medical advances. Sponsored by the ISMS Committee on Continuing Education, the bureau helps local groups arrange and conduct postgraduate medical education programs in their own areas. This assistance includes obtaining speakers, helping them with travel arrangements, preparing and mailing notices of meetings, and paying an honorarium and travel expenses. ISMS can also provide publicity services upon request.

It also pays a $50 honorarium and expenses for individual speakers obtained by county medical societies for their regular meetings.

The Bureau operates under a grant from Merck, Sharp & Dohme, which provides funds to the ISMS Educational and Scientific Foundation for the specific purpose of obtaining speakers for county medical society meetings.

The following procedures govern use of the Bureau:

1) County societies select speakers from a roster containing the names of more than 400 speakers and over 1,000 topics.

2) Eight weeks advance notice is required for postgraduate meetings. Requests for such meetings, which usually are scheduled for an entire afternoon, should be sent to the Scientific Speakers Bureau, Illinois State Medical Society, 360 N. Michigan Ave., Chicago.

3) Publicity to media in the area of the meeting will be handled by ISMS upon request of the county society.

4) Postcard notices will be mailed to physicians in the county if requested. ISMS will prepare and mail notices if the information is received no less than three weeks prior to the meeting.

5) The county medical society program chairman and the speaker are both expected to submit to ISMS a report on the meeting and the arrangements.

PHYSICIANS PLACEMENT & STUDENT LOAN FUND PROGRAM

The Illinois State Medical Society not only offers help to students who wish to become physicians, but also is able to assist the careers of those already licensed to practice medicine.

The society provides this aid through two special activities. First is its own Physicians Placement Service. Second is the Illinois Medical Student Loan Fund Program that the society sponsors in conjunction with the Illinois Agricultural Association.

Physicians Placement Service

The Physicians Placement Service is designed to help physicians find a desirable area in which to establish practice or to relocate. The program's purpose is twofold, since it is interested also in helping those communities which demonstrate need of a resident physician.

More than 550 medical doctors have been placed through this program since its inception shortly after World War II.

The Physicians Placement Service maintains an up-to-date listing of some 350 "open" areas needing general practitioners. It maintains a similar listing of areas in need of specialists in a given field.

This service accepts requests from both physicians and communities for satisfactory placement. In addition, physicians are referred to the service by a number of organizations, among them the American Medical Association, the Illinois Department of Public Health and the Illinois Agricultural Association. Frequently, responsible citizens or overburdened physicians in a community will contact the service.

Another important function of the Physicians Placement Service is to assist small communities in developing programs to attract physicians.

The Physicians Placement Service sends a questionnaire to the applicant physician to obtain information on his educational background, his interests and preferences of type of practice. Upon return of the questionnaire, the physician is sent a complete list of openings. Each opening is detailed on its facilities for home life, office space, proximity to hospital facilities and other specifics. The physician is also sent bulletins with information on new locations as they develop.

The Physicians Placement Service offers its assistance to all qualified physicians who request it. An applicant need not be a member of the state medical society. There is no charge either to the physician or to the community seeking the services of this program.

Illinois Medical Student Loan Fund Program

The Illinois Medical Student Loan Fund Program is designed to help those who have what it takes to become a physician, but lack sufficient financial resources, or a recommendation for medical school.

Loans to students in need are provided by joint contributions from the Illinois State Medical Society and the Illinois Agricultural Association. The program offers loans u pto $750 per semester—up to a total of $6,000 over a five-year period. A low interest rate is charged semi-annually from the time the loan is received. The borrower also must insure himself for the entire amount of the loan and pay premiums on the policy. Repayment begins January 1 of the fifth year following medical school graduation.

The program also offers assistance to those who may not have financial difficulties but are denied matriculation into medical school because their college grades are marginal. The board representing the sponsoring organizations of the program can recommend candidates annually to the University of Illinois College of Medicine in Chicago. After careful screening to determine whether the applicant has the potential to make a good medical student, the board can recommend him for admittance on the basis of its investigation.

In return for this assistance from the Medical Student Loan Fund Program, the applicant must agree to practice medicine in an Illinois town—serving a rural population for five years. The applicant may select a town from an up-to-date list of communities which have demonstrated need and ability to support a physician, but choice is subject to approval by the program's board. The purpose of this agreement is to provide family doctors for the rural communities in Illinois.

To be considered for assistance from the Medical Student Loan Fund Program, an applicant must be recommended by the presidents of his home county medical society and farm bureau. Rules of eligibility require that an applicant be a premedical student of at least three years college standing; that he take a medical college ad-

missions test; and that his college grade transcript be submitted with the completed application form. Illinois residency is not required.

The board of the Medical Student Loan Fund Program conducts its annual interview in December for those students who wish to enter medical school the following September. Those approved for assistance are accepted on a comparative and competitive basis. Information and applications may be obtained from Roy E. Will, secretary, Joint Medical Student Loan Fund Board, Illinois Agricultural Association, 1701 Towanda Ave., P.O. Box 901, Bloomington.

IMPARTIAL MEDICAL TESTIMONY

The Impartial Medical Testimony program, in which the Illinois State Medical Society participates, is designed to elicit objective medical truth and facilitate the equitable disposition of injury cases in the courts of Illinois.

As a technique of judicial administration, impartial medical testimony examiners are ordered by the court when there is evidence of a wide divergence of medical opinion in the injury which is subject to litigation. The introduction of the IMT examiner and subsequent examination of injuries provide the court with objective, impartial medical data for use in pre-trial conferences and in jury trials.

Authorization for the use of IMT examiners was established by the introduction of Illinois Supreme Court Rule 17-2 in September, 1961.

Illinois is distinquished in this matter by being the only state which has a court rule permitting the state-wide use of impartial medical testimony. The Illinois State Medical Society played a significant role in the creation and development of the IMT program. Impartial medical testimony in other states is limited to certain jurisdictions within the states.

The Illinois State Medical Society panel of impartial medical examiners is comprised of approximately 250 physicians who are grouped into some 20 medical specialties. Composition of the panel is reviewed annually to maintain the highest standards for the courts of Illinois.

The Illinois State Medical Society is appreciative of its role in offering, in conjunction with the Supreme Court, impartial medical service for the courts of Illinois. The IMT Committee of the state society is charged with the responsibility of maintaining the IMT panel of qualified physicians, as required by the court.

INSURANCE PROGRAMS

Retirement Investment Program

The Board of Trustees of the Illinois State Medical Society has approved the *Retirement Investment Program* which makes available to members a means of providing for retirement with group advantages an individual physician could not otherwise obtain. The Tax Qualified Retirement Program (Keogh) and the Retirement Investment Program permit balanced investments to counter economic fluctuations.

Annuities or mutual funds alone do not meet the problems of recession and inflation, but together they do permit a sound retirement plan.

The group annuity provides a guaranteed lifetime income at retirement, serving as a hedge against periods of recession or declining prices, while the mutual fund provides an opportunity for common stock investment serving as a hedge against periods of inflation or rising prices.

A member physician wishing this type of retirement protection may obtain it through the Illinois State Medical Society. By doing, so he not only receives advantages he would not otherwise have, but he is able to benefit from the collective opinions and research facilities of the insurance company and the mutual fund's investment advisor.

The *Retirement Investment Program*, making available the group annuity at a substantial reduction in premium, and the mutual funds, is one of the most recent of its kind. This program was developed after several years of study taking into consideration other group plans and retirement alternatives.

The size of the retirement contribution, the proportion of investment between the group annuity and the mutual fund, and the retirement age are determined by the participating physician.

The National Boulevard Bank of Chicago receives all physicians' contributions, and maintains records.

Group Annuity

The group annuity, underwritten by the Continental Assurance Co., participates in dividends which are reinvested annually at compound interest.

The group annuity may provide an insurance death benefit and a total and permanent disability guarantee. In the event of death prior to retirement, a member's beneficiary would receive the death benefit or the cash value of the annuity, whichever is greater.

Six options for settlement at retirement are available under the annuity. The most frequently

chosen is the life income option which guarantees a base income for life that can never be outlived. With the increase of life expectancy, there is a danger of depleting capital during advanced years. However, the group annuity assures, at least, a base or fixed income which cannot be outlived. Of equal importance is the fact that settlement may be arranged under the group annuity to guarantee at least a return of the member's investment to his beneficiary, if he elects a life income and dies shortly after retirement.

Mutual Fund

The open end mutual fund consisting primarily of common stocks is Massachusetts Investors Growth Stock Fund which is underwritten by Vance Sanders & Company of Boston. The assets of the fund are over one billion dollars. Its sister fund, Massachusetts Investors Trust, is the nation's oldest mutual fund. The Growth Fund is offered with an 8-1/2% sales charge and the Investment Adviser, Massachusetts Financial Services Inc., receives an investment advisory fee of .09% per annum. The fund is quoted daily in most major newspapers including the *Wall Street Journal* Vance Sanders & Company Inc., underwrites a group of mutual funds whose net asset value exceeds 4 billion dollars.

Group Disability Program

The Illinois State Medical Society's officially approved *Group Disability Program* is available to all eligible members of ISMS up to age 70 who are regularly attending all of the usual duties of their occupation. Three different types of coverage are available under the program, with an over-70 conversion privilege.

Benefits of the program are payable regardless of any other insurance and no restrictive riders may be attached after issuance. The master contract contains a special renewal condition whereby the individual coverage cannot be terminated.

Provision has been made for an adjudication committee to advise the carrier on claims and other administrative problems. The adjudication committee will review the medical data and make recommendations regarding coverage which the insurance company might otherwise reject.

The program is explained in detail in a brochure which is available by writing to Parker, Aleshire & Co., 9933 Lawler Ave., Skokie 60076.

Group Major Medical Expense Plan

A $25,000 *Group Major Medical Expense Plan* designed for the Illinois State Medical Society has a 20% co-insurance feature and a $500 or $1,000 deductible, whichever the physician selects. For hospital room and board, the Plan will pay up to $50 a day and in addition up to $45 a day in an intensive care unit. It will pay $20 a day in a convalescent home following release from a hospital up to 90 days. The Plan also provides maximum coverage for the insured in the event of mental illness and up to $2,000 for dependents. It will also cover a congenital abnormality from the first day of birth after the effective date of the contract up to $2,000.

New members joining the Society will be allowed to enroll without evidence of insurability or a health statement under age 40 within six months after notification of the Plan's availability.

The Group Major Medical Expense Plan is outstanding and will provide members with protection against catastrophic illness.

The Plan is underwritten by the Commercial Insurance Co. of Newark, N.J., and is administered by Parker, Aleshire & Co., Skokie 60076. Additional information may be obtained from the Illinois State Medical Society.

Hospital Income Plan

The Hospital Income Plan, approved by the Board of Trustees March 14, 1971, is available exclusively as a benefit to ISMS members. The society derives no income from sponsorship.

The Plan pays $25 in cash (Plan A) or $50 in cash (Plan B) for each day the participant is confined to a hospital because of accident or illness for as long as one full year, up to $9,125 (Plan A) or $18,250 (Plan B) for each accident or sickness.

All active members of the society, their employees and their families are eligible for participation during enrollment periods conducted by the Administrator, Paul H. Robinson, Jr., Administrative Services, Inc., 209 S. LaSalle St., Chicago 60604.

The daily benefits are automatically doubled for all participants under age 65 for hospital confinement due to cancer or hospital confinement in an intensive care unit.

The plan pays regardless of any insurance members have, and in addition to Medicare and Social Security benefits. Benefits are paid directly to the participant and not to a doctor or hospital. Benefits are not taxable and, therefore need not be included in your tax return.

The coverage is limited to sickness which commences or accidents which occur while the insurance is in force. However, conditions pre-existing the effective date of insurance will be covered if the participant has not received treatment or medical advice during any period of 12 consecutive months ending after the effective date of insurance. After 2 years from the effective date of insurance, coverage is guaranteed regardless of any pre-existing conditions.

The plan includes these exclusions: War or act of war, service in the armed forces of any country or international authority at war, pregnancy (including childbirth or resulting complications), or intentionally self inflicted injuries, suicide or attempted suicide, whether sane or insane.

In summary, in 1971 the Hospital Income Plan was made available to the membership and was received very well. During the initial enrollment period all members regardless of age could participate. However, in future enrollment periods participation will be limited to members under age 65. Enrollment periods are anticipated every 12 to 18 month.

Tax-Qualified Retirement Program

As mentioned above, the Board of Trustees has also approved the Society's *Tax-Qualified Retirement Program,* which utilizes a Continental Assurance Company Group Annuity and the Massachusetts Investors Growth Stock Fund. This program is intended for members who may find the provisions of the Keogh Act to their advantage. A liberalization, effective in 1968, which will allow contributions made by self-employed physicians to be fully deductible has made this Program more attractive to the membership. The principal provisions of the Keogh Act are as follows:

1. A self-employed physician may set aside 10% of his net income from the practice of medicine or $2,500.00 whichever is the lesser, each year for his own retirement.
2. A self-employed physician may deduct all of this amount from his income tax.
3. A self-employed physician must include all full-time employees with three or more years service under the Plan. A full-time employee is defined as an employee working twenty hours or more a week for a period of five or more months. The employee's contributions are made by the physician as a percent of salary at least equal to that percentage of net income put aside by the physician for his own retirement.
4. Funds invested under the Tax-Qualified Retirement Program accumulate tax free until distribution.

National Boulevard Bank of Chicago acts as Trustee for the Program's Annuity and Stock Fund shares and receives all physicians' contributions and maintains the Program's records.

Members who are incorporated, or are considering incorporation, may wish to receive the information pertaining to the Illinois State Medical Society IRS approved Corporate Pension and Profit Sharing Plans. This information together with the information pertaining to the ISMS Retirement Investment Program or the Keogh Act Program may be obtained by writing the Plan Administrator: Paul H. Robinson, Jr. Inc., Administrator, ISMS Retirement Programs, 209 South LaSalle Street, Chicago, 60604.

Professional Liability Program

An ISMS-Sponsored *Malpractice Liability Insurance Program* became available to members after it was approved by the Board of Trustees and the State of Illinois Insurance Department. All members may enroll in it at any time.

The Program was devised as an answer to the physician's complaints of arbitrary policy cancellations due to high risk specialty, age, abrupt increases in premium rates and headlong out of court settlements.

The underwriter of the program is Employers' Group of Insurance Companies, an 83 year old Boston firm. The administrator is Parker, Aleshire & Company, Skokie, which has served ISMS on other insurance plans since 1946.

Here are some key features of the program:

1. Coverage is available regardless of age, area in state in which member practices, or specialty.
2. ISMS directly supervises and controls the program, in conjunction with the administrator and underwriter. No policy will be declined or cancelled without just cause and a review by an ISMS designee. Any proposals for premium rate increases or other changes will be submitted to the Insurance Committee for review and acceptance. Firm steps are being taken to improve the legal climate in Illinois. No claims will be settled without the written approval of the insured. Outstanding defense counsels, expert in malpractice cases, have been retained. The legal profession has been notified that every nuisance claim will be fought. An educational program emphasizes claim prevention techniques and informs members of malpractice trends.
3. Coverage up to $1,000,000 is available.
4. Premium rates are in line with those charged by other insurers. A unique premium saving feature makes the plan especially attractive to the member engaged in corporate practice. A better legal climate will help stabilize the rates because rates will reflect the loss experience as it occurs in Illinois.

Full details and application forms may be obtained from Parker, Aleshire & Company, 9933 North Lawler Avenue, Skokie, Illinois 60076 or by calling 312-679-1000.

Personal Life Insurance Program

A guaranteed renewable term life insurance program was offered to ISMS members for the first time in 1972. Recommended by the Insurance Committee and approved by the Board of Trustees, a guaranteed issue of $10,000 or $20,000 of term life insurance was offered during a summer enrollment period. Features of the program include future purchase privileges, no evidence of insurability, optional family insurance, and guaranteed conversion privileges up to age 70.

Ancillary Organizations

Woman's Auxiliary To The Illinois State Medical Society

1972-73 is a year to reminisce—to test the strength of the past and recapture the dreams of the young. The fine spirited group of women in the Woman's Auxiliary to the Illinois State Medical Society have seized the times. The emphasis being on the old idea of caring and getting to know you. Important activities and changes are in motion due to the intensive re-evaluation of priority care needed in this space age.

Surprisingly, the original aims of the Auxiliary which are to: 1) assist the ISMS in the advancement of medicine; 2) insure good legislation; 3) act as liaison between profession and the public; 4) cultivate friendly relations among physicians' families.

These ideals were highlighted and reviewed in the slide presentation at the 50th Anniversary celebration of the Woman's Auxiliary to the American Medical Association, at the June Convention held in San Francisco. It also reinforced that we definitely are a three part unit: 1) national, 2) state, and 3) county. Similar to a chain that is as strong as its weakest link, the National Auxiliary in a capsule gives to each state the progress of the fifty states. Each state is unique with its own set of problems of size, geographic area, social and economic structure. These are the qualities that make up the fabric of the Woman's Auxiliary in the United States and as such is influenced in a small way by the auxiliary member. The apathy of indifference felt in every organization shown by slipping membership has been evolving over several decades. The worth and honor of belonging is no longer coveted. This in part is due to the fact that the responsibility of working and earning recognition by the individual has been relinquished to government and other agencies. However, there is a quiet turn-about at the county, state and national level making it clear the individual does care. Many counties, Peoria, Will-Grundy and Rockford to mention a few, are in fact beginning to re-organize the structure to handle these momentous changes.

No doubt about it, we are proud of Illinois' accomplishments. For instance, three Illinois State past presidents serve national: Mrs. Willard Scrivner, President-Elect; Mrs. Wendell Roller, North Regional Vice-President; and Mrs. Sherman Arnold, Regional Chairman of AMA-ERF. Moreover, these capable ladies are willing to give us their hearts, talents, and experience for the continued growth of our goals.

Further, Illinois will take action and follow, in our newly distributed programs issued thru the Community Health Chairman and the Program Chairman, he suggestions of the American Medical Association together with other organizations.

Subsequently, our various chairmen will work at the local level on these fronts. The first step will be to evaluate the duplication of services in local organizations, with emphasis on consolidating facilities. These programs, which are relevant to health education regarding growth and development, are to be made available to children of all ages and parents. The programs will be included in day centers, nursery schools and health care centers and schools in every community.

One of the important activities for the 3000 members is to participate in the combined district meetings. The latest literature is distributed, new phases of auxiliary work announced and the opportunity thru this encounter and meet and "get to know" one another which is appropriately enough the auxiliary theme. Another important function of this gathering is to elect the councilor. She is elected for a two year term. We elect half on the even year and the other half on the odd year to maintain continuity. Combined districts of 1, 2, 3 and 11 scheduled for September 12, 1972 met at the American Medical Association Auditorium. This includes the members-at-large of Cook County Branches, Iroquois, Ford, Kane, Livingston McHenry, Ogle, and Woodford: The combined Districts of 4, 5, 6, 7, and 8 were to meet October 17, 1972 in Peoria, which includes members-at-large of Coles-Cumberland, Bond, Clark, DeWitt, Effingham, Douglas Edgar, Fayette, Fulton, Christian, Hancock, Henderson, Henry-Stark, Jasper, Jersey-Calhoun, Logan, Mason, Macoupin, Morgan-Scott, McDonnough and Pike. The combined districts of 9 and 10 will meet November 9, 1972 in Belleville, which includes members-at-large of Monroe, Perry, Randolph, Saline-Pope-Hardin, Union, Wabash, and Wayne.

The function of the board which meets four times a year is to cover the general business with numerous special committee meetings scheduled as needed. A meeting was held on September 11th at the Illinois State Medical Society office. February 5th the board will meet at the American Medical Association auditorium. The County Presidents' reports are submitted to the Executive Secretary by January 1, 1973 for inclusion in the Convention Delegates' Handbook. The County Treasurer sends our membership dues to our State Treasurer by December 15th, so a convention delegate count can be established by January 1, 1973. We wish to commend the Chicago and Peoria Auxiliaries, comprising the Illinois groups of the Woman's Auxiliary to the Student American Medical Association, for their activities during the past year. An acknowledgment also must go to our Executive Secretary, Mrs. Robert Swanson, with offices in Monmouth.

Our publication, a circulated newsletter previously known as "Pulse," is now being channeled thru the *Illinois Medical Journal*. Our activities, programs and ideas can be followed monthly in the *IMJ* indexed under "pulse of the doctor's wife."

Each paid auxiliary member also receives from national *MD's Wife* magazine issued September, November, January, March, May and July. "Direct Line" is sent from national in summer, fall and spring.

I am happy to report that during 1971-72 the auxiliary raised a total of $18,500 to provide scholarship and financial aid through Benevolence, and the American Medical Association-Education Research Foundation.

The 45th Annual Convention will be held jointly with the Illinois State Medical Society and the Chicago Medical Society on March 25-28, 1973 at the Conrad Hilton, Chicago.

In five years we in Illinois will be celebrating our 50th Anniversary. We set our goal—fifty counties of dedicated doctors' wives to continue to assist the Illinois State Medical Society. It is a reminder that you can count on us —and we are proud to serve you.

Mrs. August Martinucci
President

OFFICERS

President Mrs. August Martinucci
1210 Mason Avenue, Joliet 60435
President-Elect Mrs. Robert Hartman
1040 W. College, Jacksonville 62650
Vice-President (Community Health) Mrs. Joseph Shanks
3121 Sheridan Road, Chicago 60657
Vice-President (Program) Mrs. Thomas Tourlentes
Valley View Road, Route 2 Galesburg 61401
Vice-President (Membership) Mrs. John Ovitz, Jr.
427 S. Main, Sycamore 60178
Recording Secretary Mrs. Bernard Baalman
Hardin 62047
Corresponding Secretary Mrs. Noel Bass
1400 Mason, Joliet 60435
Treasurer Mrs. William Hodges
1000 S. Wildwood Ave., Kankakee 61401

DIRECTORS

Mrs. David Kweder
1432 N. Sheridan Road, Waukegan 60085
Mrs. Mitchell Spellberg
1212 N. Lake Shore Drive, Chicago 60610
Mrs. Eugene L. Vickery
602 Oak Street, Lena 61048

EXECUTIVE SECRETARY

Mrs. Robert Swanson
National Bank of Monmouth Bldg. Monmouth 61462

COMMITTEE CHAIRMEN

AMA-ERF Mrs. Earl Klaren
220 Walnut, Liberytville 60048
Archives Mrs. Sherman Arnold
2416 Brookwood Drive, Flossmoor 60422
Benevolence Mrs. Robert Kooiker
801 Lincoln Avenue, Jacksonville 62650
Community Health Mrs. Joseph Shanks
3121 Sheridan Road, Chicago 60657
Convention Mrs. Ralph P. White
1101 N. Kenilworth Parkway, Oak Park 61302
Convention Vice-Chairman Mrs. Harold Kass
712 Courtland Circle, Western Springs 60558
Credentials Mrs. Robert Joel Lee
1639 E. 92nd Street, Chicago 60617
Credentials Vice-Chairman Mrs. Richard Bowman
600 Valley Rd., Itasca 60143
Editorial Mrs. Robert Hart
915 Sunset Drive CMR 19, East Peoria 61611
Finance Mrs. Joseph O'Donnell
1109 E. Willow, Wheaton 60187
Health Careers Mrs. Thomas Glatter
2407 Spring Brook Avenue, Rockford 61107
Home Centered Health Care Mrs. Jack D. Clemis
734 Lavergne Avenue, Wilmette 60091
Hospitality Mrs. Leo Kempton
21W268 Shelly Drive, Itasca 60143
Hospitality Vice-Chairman Mrs. Hurbert Swartout
314 Cottage Hill Avenue, Elmhurst 60126
International Health Mrs. R. S. Hoover
1752 Highland Drive, Freeport 61032
Legislation-IMPAC Mrs. Alan Taylor
1607 N. Vermilion, Danville 61832
Members-at-Large Mrs. Wilson West
14 Oakwood Drive, Belleville 62223
Members-at-Large Vice-Chairman Mrs. O. E. Barbour
4119 Hollyridge Circle, Peoria 61614
Membership Mrs. John Ovitz Jr.
427 S. Main, Sycamore 60178
Mental Health Mrs. John Koenig
2518 Oakwood Drive, Olympia Fields 60461
Organization Mrs. Robert Hartman
1040 W. College, Jacksonville 62650
Press/Publicity Mrs. Donovan Stiegel
2920 15th Avenue, Moline 62165
Program Mrs. Thomas Tourlentes
Valley View Road, Route 2, Galesburg 61401
Public Affairs Mrs. Harlan Failor
9 Litchfield Lane, Champaign 61820
Revisions-Resolutions Mrs. Herbert Cibul
2801 N. Sheridan Road, Chicago 60657
Rural-Urban Health Mrs. William Schowengerdt
Route 2, S. Prospect Road, Champaign 61820
Safety Mrs. Vernon L. Guynn
608 N. Third Avenue, St. Charles 60174
WA/SAMA Mrs. Edward Szewczyk
17 Oak Knoll, Belleville 62223

AD HOC COMMITTEES

Children & Youth Mrs. Wendell Roller
309 S. Main, Box 664, Monmouth 61462
Religion & Medicine Mrs. Clement Cunningham
2921 27th Street, Rock Island 61201

PARLIAMENTARIAN

Mrs. Percy Clark
5722 Franklin Avenue, LaGrange 60525

DISTRICT COUNCILORS

District

1. Mrs. Emanuel Herzon
 150 Sherwood Road, Elgin 60120
2. Mrs. Allan Goslin
 Route 4, Streator, 61364
3. Mrs. Oliver V. Renaud
 11908 Laurie Avenue, Palos Park 60464
 Mrs. Ralph P. White
 1101 N. Kenilworth Avenue, Oak Park 60302
 Mrs. Joseph Shanks
 3121 Sheridan Road, Chicago 60657
4. Mrs. Lowell C. Neveln
 576 N. Chambers, Galesburg 61401
5. Mrs. Stanley Burris
 1630 Wiggins, Springfield 62704
6. Mrs. Ralph Davis
 2639 Vermont, Quincy 62301
7. Mrs. Joseph Ankenbrandt
 600 Powers Lane, Decatur 62522
8. Mrs. Stanley Levin
 1107 Lake Ridge Road, Danville 61732
9. Mrs. Renato Souza
 515 S. Calumet, Marion 62959
10. Mrs. Robert Hardin
 5 Kilmar Woods, Belleville 62223
11. Mrs. Edward Svetich
 813 Buell Ave., Joliet 60435

Illinois Medical Political Action Committee (IMPAC)

The Illinois Medical Political Action Committee (IMPAC) is a voluntary, non-profit, unincorporated, permanent membership organization founded in 1960. IMPAC serves as the unified political action arm of Illinois physicians and their wives. It cooperates with others in the healing arts professions. Funds collected through IMPAC memberships, used in support of candidates, are administered independently of other professional groups. However, the program is operated in harmony with the legislative objectives of the Illinois State Medical Society. Individual participation in IMPAC is one means by which the individual physician and his wife can effectively participate in public affairs.

IMPAC participates primarily in election contests for legislative offices—both those in the Illinois General Assembly and in the U. S. Congress. It cooperates, both in election efforts and in membership solicitation activities, with the American Medical Political Action Committee (AMPAC), its counterpart on the national level.

IMPAC's organization consists of a chairman, an executive committee, and a council. Political action activities are implemented by local physician support committees formed on behalf of candidates in U. S. Congressional or other legislative districts. Candidate selection and support are determined on the basis of evaluations and recommendations submitted to the council and executive committee by the local committees, thus assuring members of a "grass roots" voice in IMPAC activities.

Additional information about IMPAC may be obtained by writing: IMPAC, Suite 2010, 360 N. Michigan Ave., Chicago 60601.

American Association of Medical Assistants Illinois Society

The American Association of Medical Assistants—Illinois Society—is just what the name implies—an association of medical assistants throughout the State of Illinois who have become an educational organization with objectives as follow: (a) to maintain and advance the standards of professional employment and to give honest, loyal and efficient service to the medical profession and the public; (b) to assist the physicians in improving medical public relations; (c) to bring into one association all medical assistant organizations of the state of Illinois; (d) to provide an organization for those residing in Illinois; counties where no medical assistant societies are organized; (e) to meet from time to time to secure interchange of ideas.

This association is an educational group—*not social.* It is not a union, and any attempt to promote the unionization of this society or its members automatically forfeits the membership of the person or persons making such an attempt.

Medical Assistants in counties join together to form component chapters of AAMA, Illinois Society. At present, there are active chapters in the following counties: Cook (3), Kane, Lake, McHenry, Kankakee, Vermilion, DuPage, DeKalb, Will-Grundy, Peoria Tazewell, Macon, Sangamon, Williamson-Jackson-Franklin, St. Clair, Madison, Jefferson-Hamilton, Rock Island, Stephenson, Fulton, McLean and LaSalle. Monthly programs of the local chapters are geared to the needs of that particular area. Therefore, the educational programs are decided by the local medical assistants and supervised by the doctors in the county medical society.

Education is promoted by the Illinois Society by sponsoring (1) Traveling Courses throughout the state, (2) an Educational Symposium each September, (3) a three-day annual meeting each April and (4) informative articles in our publication "The Illini Cardinal."

The qualified medical assistant has the opportunity to pass a special board examination and become a "certified Medical Assistant." Of note is the fact that you do not have to belong to the Association to take this examination. For further information as to qualifications necessary to take the examination, write to American Association of Medical Assistants, One East Wacker Drive, Suite 1510, Chicago 60601.

Doctors should encourage their medical assistants to join the association. Also, doctors can help the association by assisting in the selection of educational programs that will enable the members to become better medical assistants.

OFFICERS

President—Mrs. Richard Hall
1217 Sheridan Street, Danville 61832
President-Elect—Mrs. John Domanic
150 Ash Street, New Lenox 60451
First Vice-President—Mrs. Vivian Johnson
9105 S. Albany Street, Evergreen Park 60642
Second Vice President—Mrs. Donna Broad
437 Burke Drive, Joliet 60433
Speaker of House—Mrs. Synobia Payne
10022 S. Princeton, Chicago 60628
Recording Secretary—Mrs. Harold Soladay
1009 Victoria Street, Antioch 60002

Corresponding Secretary—Mrs. John Fenwick
Muncie, Illinois 61857

Membership Secretary—Mrs. Luella Mitchell
7920 Eberhart Street, So. Chicago 60619

Treasurer—Mrs. Magda Brown
4250 Main Street, Skokie 60076

Board of Trustees, *Chairman* Miss Ina Yenerich
839 Jefferson St., Elgin 60120

Education Committee, *Chairman* Miss Jean Berschinski
1805 Evergreen Road, Homewood 60430

ADVISORS

Carl Clark, M.D., *ISMS Liaison*
225 Edward Street, Sycamore 60178
Allison Burdick, Sr., M.D.
5906 West North Avenue, Chicago 60639
John L. Wright, M.D.
408 Griesheim Bldg., Bloomington 61701

Thomas R. Harwood, M.D., *Chairman*
365 Moraine Road, Highland Park 60035
D. J. Ladd, M.D.
901 North First Street, DeKalb 60115
Daniel Parr, M.D.
Tremont

The Educational & Scientific Foundation

The Educational & Scientific Foundation was founded to provide an administrative agency to foster the advancement of clinical science through:

1) The initiation of scientific and medical research activities.

2) The collection, evaluation and dissemination of the results of research activities to the public.

3) The implementation and management of projects related to medicine for individuals, or organizations seeking to inform or educate others, or to improve their own knowledge.

The Foundation is a distinct corporate entity which has an interlocking Board with the Illinois State Medical Society. It is staffed through ISMS headquarters.

Illinois Council on Continuing Medical Education

The Illinois Council on Continuing Medical Education is an independent not-for-profit corporation created by the Illinois State Medical Society to provide a multi-organizational approach to continuing education.

The concept of an independent statewide council and voluntary participation in continuing education programs is viewed as a means of averting compulsory re-licensure of physicians by re-examination. The AMA and various state medical organizations have placed increasing emphasis on continuing medical education, with some requiring it for membership.

It has been thought that the Illinois State Medical Society itself was not in a position to do the whole job alone, but that it had a responsibility to join with others in making meaningful continuing education programs readily accessible to the physicians of Illinois. In 1970, the House of Delegates endorsed in principle this concept.

In 1971, the House of Delegates provided initial financing for the council by allocating for one year $10 from the portion of dues designated for AMA-ERF. Adoption of bylaws, appointment of a Board of Directors and incorporation by the state followed. In 1972, an Executive Director was employed to carry out the purposes of the Council. These purposes are:

1. To make readily available to all Illinois physicians continuing medical education programs that will enhance patient care.

2. To catalog and coordinate existing educational programs and eliminate wasteful duplication of effort.

3. To study and encourage development of new educational methods, techniques, systems, etc.

4. To discover educational needs of physicians locally through selftesting and other motivational devices.

5. To seek out potential providers of educational programs and to serve as liaison between producers and consumers.

6. To stimulate, motivate and encourage physicians at all levels through the state to participate in formal continuing education programs.

Illinois Foundation for Medical Care

The Illinois Foundation for Medical Care is a corporation of physicians, sponsored by the ISMS, that designs, monitors and directly participates in the administration of private and governmental health care programs. IFMC was established in July, 1971, at the request of the ISMS' House of Delegates.

Through the Foundation, physicians have a direct leadership role in the development and administration of health care programs. IFMC is capable of contracting with the government to become a Professional Standards Review Organization (PSRO)—if such legislation is established—or to experiment with new kinds of health care delivery systems such as Health Maintenance Organization (HMO) on a fee-for-service open panel basis. This flexibility places IFMC in a desirable position to accommodate any new proposal for the delivery of health care.

Thus far, IFMC has developed a Hospital Admission & Surveillance Program (HASP) that certifies lengths of

hospital stays for all Medicaid patients. Since it began early this year, HASP has proven its effectiveness saving the state millions of dollars without sacrificing the quality of care. IFMC intends to utilize he HASP concept in future program activities.

Membership in IFMC is available to any licensed physician or osteopath qualified to practice medicine in all its branches and who is eligible for membership in ISMS. Information can be obtained by writing IFMC, 360 N. Michigan Ave., Suite 1418, Chicago, 60601.

Medical and Paramedical Education

MEDICAL SCHOOLS IN THE STATE OF ILLINOIS

Chicago Medical School
2020 W. Ogden Ave., Chicago, 60612

Northwestern University Medical School
303 E. Chicago Ave., Chicago, 60611

University of Chicago Pritzker School of Medicine
950 E. 59th Street, Chicago, 60637

University of Illinois College of Medicine
1853 W. Polk Street, Chicago, 60680
Abraham Lincoln School of Medicine, Chicago
Metropolitan Hospital Group, Chicago
Peoria School of Medicine, Peoria
Rockford School of Medicine, Rockford
School of Associated Medical Sciences, Chicago
School of Basic Medical Sciences, Chicago
School of Basic Medical Sciences, Urbana

Loyola University, Stritch School of Medicine
2160 S. First Ave., Maywood, 60153

The following are medical schools in Illinois which are presently in the developmental stages.

Rush Medical College
1753 W. Congress Parkway, Chicago 60612
(Provisional Accreditation)

Southern Illinois University Medical School
745 E. Carpenter, Carbondale, 62702
(Anticipates enrollment to begin in Summer, 1973)

APPROVED SCHOOLS FOR MEDICAL RECORD TECHNICIAN

EAST PEORIA—Illinois Central College
PALOS HILLS—Moraine Valley Community College

APPROVED SCHOOL FOR MEDICAL RECORD ADMINISTRATORS

CHICAGO—University of Illinois at the Medical Center

APPROVED SCHOOL OF PHYSICAL THERAPY

CHICAGO—Northwestern University Medical School

APPROVED COURSE IN OCCUPATIONAL THERAPY

CHICAGO—University of Illinois-School of Associated Medical Service

APPROVED SCHOOLS OF INHALATION THERAPY

CHICAGO—Cook County Hospital, Edgewater Hospital, Northwestern University Medical Center, Rush-Presbyterian-St. Lukes Hospital, University of Chicago Hospitals
HINES—Veteran's Administration Hospital
MOLINE—Lutheran Hospital
PALOS HILLS—Moraine Valley Community College
RIVER GROVE—Triton College
ROCKFORD—St. Anthony Hospital
SPRINGFIELD—Springfield Memorial Hospital

APPROVED SCHOOLS OF CERTIFIED LABORATORY ASSISTANTS

ARLINGTON HEIGHTS—Northwest Community Hospital
CHICAGO—St. Elizabeth Hospital, Swedish Covenant Hospital, Veterans Administration West Side Hospital
CRYSTAL LAKE—McHenry County College
DANVILLE—St. Elizabeth Hospital
DIXON—Sauk Valley Junior College
ELGIN—Sherman Hospital
OAK PARK—Oak Park Hospital
QUINCY—Blessing Hospital
OLNEY—Richland Memorial Hospital

APPROVED SCHOOLS OF CYTOTECHNOLOGY

CHICAGO—Michael Reese Medical Center, Mount Sinai Medical Center, University of Chicago Hospitals and Clinics

APPROVED SCHOOLS OF MEDICAL TECHNOLOGY

AURORA—Copley Memorial Hospital

BELLEVILLE—St. Elizabeth Hospital

BLUE ISLAND—St. Francis Hospital

CHAMPAIGN—Burnham City Hospital

CHICAGO—Augustana Hospital, Chicago Medical School—Univ. of Health Sciences, Northwestern Memorial Hospital, Edgewater Hospital, Grant Hospital of Chicago, Holy Cross Hospital, Illinois Masonic Medical Center, Louis A. Weiss Memorial Hospital, Mercy Hospital and Medical Center, Michael Reese Hospital and Medical Center, Mount Sinai Hospital and Medical Center, Northwestern University Medical School, Rush-Presbyterian-St. Luke's Hospital, St. Anne's Hospital, St. Anthony's Hospital, St. Joseph Hospital, St. Mary of Nazareth Hospital, University of Illinois School of the Medical Sciences and Veterans Administration Research Hospital

CHICAGO HEIGHTS—St. James Hospital

DANVILLE—Lake View Memorial Hospital

DECATUR—Decatur Memorial Hospital and St. Mary's Hospital

ELK GROVE VILLAGE—St. Alexius Hospital

EVANSTON—Evanston Hospital, St. Francis Hospital

EVERGREEN PARK—Little Company of Mary Hospital

FREEPORT—Freeport Memorial Hospital

GENEVA—Community Hospital

GREAT LAKES—U.S. Naval Hospital

HARVEY—Ingalls Memorial Hospital

HINSDALE—Hinsdale Sanitarium and Hospital

JOLIET—Silver Cross Hospital, St. Joseph Hospital

MAYWOOD—Loyola University Center

OAK LAWN—Christ Community Hospital

OAK PARK—West Suburban Hospital

PARK RIDGE—Lutheran General and Deaconess Hospitals

PEORIA—Methodist Hospital of Central Illinois and St. Francis Hospital

QUINCY—St. Mary's Hospital

ROCKFORD—Rockford Memorial Hospital, St. Anthony Hospital and Swedish-American Hospital

SPRINGFIELD—Springfield Memorial Hospital, St. John's Hospital

URBANA—Carle Foundation Hospital

WAUKEGAN—St. Therese's Hospital

WINFIELD—Central Dupage Hospital

APPROVED SCHOOLS FOR NUCLEAR MEDICINE TECHNOLOGY

CHICAGO—Northwestern Memorial Hospital

HINES—Veterans Administration Hospital

APPROVED SCHOOL FOR RADIATION THERAPY TECHNOLOGISTS

CHICAGO—Rush-Presbyterian-St. Luke's Medical Center Hospital

APPROVED EDUCATIONAL PROGRAMS FOR HISTOLOGICAL TECHNICIAN

CHICAGO—St. Joseph Hospital, University of Chicago

APPROVED EDUCATIONAL PROGRAMS FOR RADIOLOGIC TECHNOLOGISTS

ARLINGTON HTS.—Northwest Community Hospital

AURORA—Copley Memorial Hospital
St. Joseph Mercy Hospital

BLOOMINGTON—Bloomington-Normal Hospital

CENTRALIA—St. Mary's Hospital

CHAMPAIGN—Burnham City Hospital

CHICAGO—Cook County Hospital
De Paul University
Edgewater Hospital
Englewood Hospital
Franklin Boulevard Community Hospital
Henrotin Hospital
Illinois Masonic Medical Center
Louis A. Weiss Memorial Hospital
Malcolm X College
Michael Reese Hospital and Medical Center
Mt. Sinai Hospital and Medical Center
Northwestern Memorial Hospital
Norwegian-American Hospital, Inc.
Provident Hospital and Training School
Ravenswood Hospital
Roseland Community Hospital
Rush-Presbyterian-St. Luke's Hospital
St. Anne's Hospital
St. Bernard's Hospital
St. Joseph Hospital
St. Mary of Nazareth Hospital
South Chicago Community Hospital
Sydney R. Forkosh Memorial Hospital
Woodlawn Hospital

DANVILLE—Lake View Memorial Hospital

DECATUR—Decatur Memorial Hospital

DIXON—Sauk Valley College

EAST ST. LOUIS—Centreville Township Hospital and Belleville Area College

ELGIN—St. Joseph Hospital

ELMHURST—Memorial Hospital of Du Page County

EVANSTON—St. Francis Hospital
Evanston Hospital

EVERGREEN PARK—Little Company of Mary Hospital

GALESBURG—Carl Sandburg College

GLEN ELLYN—College of DuPage

HINSDALE—Hinsdale Sanitarium and Hospital

JOLIET—Silver Cross Hospital
St. Joseph Hospital

KANKAKEE—St. Mary's Hospital
KEWANEE—Kewanee Public Hospital
MACOMB—McDonough District Hospital
MALTA—Kishwaukee Junior College
MOLINE—Lutheran Hospital
Moline Public Hospital
OAK PARK—West Suburban Hospital
OLNEY—Richland Memorial Hospital
PARK RIDGE—Lutheran General and Deaconess Hospitals
PEORIA—Methodist Hospital of Central Illinois
St. Francis Hospital
QUINCY—Blessing Hospital
St. Mary Hospital
RIVER GROVE—Triton College
ROCKFORD—Rockford Memorial Hospital
St. Anthony Hospital
Swedish-American Hospital
ROCK ISLAND—St. Anthony's Hospital
SKOKIE—Skokie Valley Community Hospital
SOUTH HOLLAND—Thornton Community College
SPRINGFIELD—Springfield Memorial Hospital
St. John's Hospital
URBANA—Carle Memorial Hospital
Mercy Hospital

APPROVED SCHOOLS OF NURSING

Associate Degree Nursing Program

A coeducational nursing program under the auspices of a junior college, two years in length and leading to an Associate Degree in Nursing. The curriculum consists of arts and sciences at the junior college level and nursing theory closely coordinated with nursing practice, under direction and supervision of the college faculty, in community hospitals and health facilities.

Graduates, both men and women, are prepared to give patient-centered care in staff nurse positions in hospitals, nursing homes and similar situations. They are prepared to cooperate and to share responsibility for the patient's welfare with other members of the nursing and health staff, and to develop their own skills through experience as practicing nurses.

General Entrance Requirements:

Good health.

High school graduation: with courses in biological and physical sciences (1-2 units of chemistry recommended) and mathematics (1-2 units recommended).

Qualification for admission to the college and the nursing curriculum.

Cost: tuition in public supported junior colleges is low, in private colleges considerably higher. Add to this: fees, books, uniforms and maintenance.

Living Arrangements: students live at home, in a college dormitory or other approved residence.

Graduate is eligible to take the state examination for licensure as a registered nurse ("R.N.").

BELLEVILLE
Belleville Area College
Department of Nursing
2555 West Blvd. 62221

CENTRALIA
Kaskaskia College
Department of Nursing
Shattuc Road 62801

CHICAGO
Amundsen-Mayfair Junior College
Department of Nursing
4626 N. Knox Ave. 60630
Kennedy-King College
Department of Nursing
7047 S. Stewart 60621
Malcolm X. College
Department of Nursing
1900 W. Van Buren 60621
Olive Harvey College
Department of Nursing
10001 S. Woodlawn 60628

CHICAGO HEIGHTS
Prairie State College
Department of Nursing
157 & Halsted 60411

CHAMPAIGN
Parkland College, Dept. of Nursing
2 Main Street 61820

CICERO
J. Sterling Morton Junior College
Department of Nursing
2500 S. Austin Blvd. 60650

DIXON
Sauk Valley College, Dept. of Nursing
River Campus, R.R. #1 61021

EAST PEORIA
Illinois Central College
Department of Nursing
Highview Road,
P. O. Box 2400 61611

ELGIN
Elgin Community College
Department of Nursing
1700 Spartan Drive 60120

GALESBURG
Carl Sandburg College, Dept. of Nursing
Box 1407 61401

GLEN ELLYN
College of DuPage
Department of Nursing
22nd & Lambert Road 60137

GODFREY
Lewis & Clark Community College
Department of Nursing
Godfrey 62035

GRAYSLAKE
Lake County College
Department of Nursing
19351 West Washington 60030

HARVEY
Thornton Community College
Department of Nursing
50 W. 162nd St., South Holland 60473

JOLIET
Joliet Junior College, Dept. of Nursing
Route #3 Houbolt Ave. 60436

KANKAKEE
Kankakee Community College
Department of Nursing
Box 888 60901

MOLINE
Black Hawk College
Department of Nursing
6600 34th Ave. 61265

OGLESBY
Illinois Valley Community College
Department of Nursing
R.R. #1 61348

OLNEY
Olney Central College of Eastern Illinois
305 N. West St. 62450

PALATINE
William Rainey Harper College
Department of Nursing
Algonquin & Roselle Roads 60067

PALOS HILLS
Moraine Valley Community College
Department of Nursing
10900 S. 88th Ave. 60465

RIVER GROVE
Triton College
Department of Nursing
2000 N. Fifth Avenue 60171

ROCKFORD
Rock Valley College 61101
Department of Nursing

SPRINGFIELD
Lincoln Land Community College
Department of Nursing
3865 S. 6th Frontage Road 62703

SUGAR GROVE
Waubonsee College
Department of Nursing
Rt. 47 Harter Road, P.O. Box 508 60554

Baccalaureate Degree Nursing Program

Usually a coeducational nursing program under the auspices of a college or university, this is generally four academic or calendar years in length. The curriculum combines general education with nursing education, leading to the Bachelor of Science Degree in Nursing. Liberal education courses, such as arts and sciences, are shared with all college students. University medical centers and other related hospital and community health agencies are utilized for nursing theory and practice.

Graduates, both men and women, are prepared for beginning nursing positions in hospitals, nursing homes and community health services, and for advancement without further formal education to positions such as "nursing team" leader or head nurse. They also have the foundations for continuing personal and professional development and for graduate study and specialization in nursing.

General Entrance Requirements:

Good health.

High school graduation: college preparatory program including biology and physical sciences (1-2 units of chemistry recommended) and mathematics (1-2 units). Two years of a foreign language may be required. Meets college or university admission standards.

Cost: college or university tuition fees for nursing programs are comparable to those for other majors. Range in Illinois is from approximately $1,000 to $7,000 for tuition and fees for total program. Other expenses: books, uniforms, maintenance.

Living Arrangements: students live at home, in a college dormitory or other approved residence.

Graduate is eligible to take state examination for licensure as a registered nurse ("R.N.").

BLOOMINGTON
Brokaw Collegiate School of Nursing
of Wesleyan University 61701

CHICAGO
DePaul University
Department of Nursing
2323 N. Seminary 60614

Loyola University
Department of Nursing
6526 N. Sheridan Rd. 60626

North Park College
Department of Nursing
5125 N. Spaulding Ave. 60625

St. Xavier College
Department of Nursing
103rd & Central Park 60655

University of Illinois
College of Nursing
P.O. Box 6998
845 S. Damen 60612

DEKALB
Northern Illinois University
Department of Nursing 60115

EDWARDSVILLE
Southern Illinois University
Edwardsville Campus
Department of Nursing 62025

KANKAKEE
Olivet Nazarene College
Department of Nursing 60901

PEORIA
Bradley University
Department of Nursing 61606

Diploma (Hospital) Nursing Program

A nursing program under the auspices of a hospital or independent school of nursing, two to three years in length, and leading to a Diploma in Nursing. A college or university may provide some of the courses. The curriculum consists of theory and practice focused primarily on instruction and related clinical experience in the nursing care of patients in hospitals. Some liberal arts courses may be included.

Graduates, both men and women, have the understanding and skills necessary to organize and implement a plan of nursing that will meet the immediate needs of one or more patients and that will promote the restoration of health. They are also able to plan with associated health personnel for the care of patients, and may be responsible for the direction of other members of the nursing team.

General Entrance Requirements:

Good health.
High school graduation: Usually upper half of class, with courses in biological and physical sciences (1-2 units, one of which should be chemistry) and mathematics (1-2 units).
Satisfactory results on entrance tests and qualification for admission to the school.
Cost: $900 to $3,500; some include full maintenance.
Living Arrangements: Schools have residence facilities; many permit students to live at home if preferred.
Graduate is eligible to take the state examination for licensure as a registered nurse ("R.N.").

ALTON
Alton Memorial Hospital
Memorial Drive 62002
St. Joseph's School
915 E. Fifth St. 62035

AURORA
Copley Memorial Hospital
Lincoln & Weston 60507

BLOOMINGTON
Mennonite Hospital
804 N. East St. 61701

CANTON
Graham Hospital
210 W. Walnut St. 61520

CHICAGO
Augustana Hospital
427 Dickens Ave. 60614
Cook County School of Nursing
1900 W. Polk St. 60612
Illinois Masonic Hospital
836 Wellington Ave. 60657
Michael Reese Hospital
2816 S. Ellis Ave. 60616
Mount Sinai Hospital
2730 W. 15th Place 60608
Northwestern Memorial Hospital
Wesley-Passavant School of Nursing
Superior and Fairbanks Court 60611
Ravenswood Hospital
1931 W. Wilson Ave. 60640
St. Anne's Hospital
4950 W. Thomas St. 60651
St. Bernard's Hospital
6344 S. Harvard Ave. 60621
St. Mary of Nazareth
1127 N. Oakley Blvd. 60622
South Chicago Community Hospital
2320 E. 93rd St. 60617

DANVILLE
Lake View Memorial Hospital
812 N. Logan Ave. 61832

DECATUR
Decatur Memorial Hospital
2300 N. Edward St. 62526

EVANSTON
Evanston Hospital Nursing Program
2645 Girard Ave. 60201
St. Francis Hospital
319 Ridge Ave. 60202

FREEPORT
Freeport Memorial Hospital
1133 W. Stephenson 61032

JACKSONVILLE
Passavant Memorial Area Hospital
1600 W. Walnut St. 62650

JOLIET
St. Joseph Hospital
333 N. Madison St. 60435

MOLINE
Lutheran Hospital
555 Sixth St. 61265
Moline Public Hospital
635 Tenth Avenue 61265

OAK LAWN
Evangelical School of Nursing
4440 W. 95th St. 60453

OAK PARK
West Suburban Hospital
518 N. Austin Blvd. 60302

PARK RIDGE
Lutheran General and Deaconness Hospitals
1775 Dempster St. 60068

PEORIA
Methodist Hospital of Central Illinois
221 N.E. Glen Oak 61603
St. Francis Hospital
211 Greenleaf St. 61609

QUINCY
Blessing Hospital
1005 Broadway 62301

ROCKFORD
Rockford Memorial Hospital
2400 N. Rockton Ave. 61103

St. Anthony Hospital
5658 E. State St. 61101

Swedish-American Hospital
1316 Charles St. 61101

ROCK ISLAND
St. Anthony Hospital
767 Thirtieth St. 61201

SPRINGFIELD
Memorial Hospital
200 N. Dodge St. 62705
St. John's Hospital
401 N. Ninth St. 62701

Practical Nursing Program

A coeducational nursing program under the auspices of public vocational education systems, hospitals or community agencies, usually one year in length. The curriculum includes nursing theory coordinated with nursing practice.

Graduates, both men and women, of programs in practical nursing are prepared for two roles: (1) under the supervision of a professional nurse or physician, they give nursing care to patients in situations relatively free of scientific complexity; (2) in a close working relationship, they assist the professional nurse in giving care to patients requiring a high degree of nursing skill and judgment.

Entrance Requirements:

Good health.
High school: Two years minimum, graduation desirable. Junior and senior students who are currently enrolled in high school are eligible to enroll in the practical nursing program as part of their credit curriculum.
Satisfactory results on entrance tests.
References and personal interview.
Cost: None under MDTA programs, to approximately $400 plus maintenance.
Living Arrangements: Students usually live at home or in housing approved by school.
Graduate is eligible to take the state examination for licensure as a practical nurse ("L.P.N.").

ALTON
F. W. Olin School of Practical Nursing
2512 Amelia Street 62002

BLOOMINGTON
Bloomington School of Practical Nursing
709 S. Clinton St. 61701

CANTON
Spoon River School of Practical Nursing

CARBONDALE
Southern Illinois University Vocational Technical Institute of Practical Nursing 62901

CHAMPAIGN
Champaign School of Practical Nursing
103 N. Prospect Ave. 61821

CHICAGO
Chicago Public Schools Practical Nursing Center
1820 W. Grenshaw 60612
Chicago Public Schools Licensed Practical Nurses Program, Manpower Division
2913 N. Commonwealth 60657
St. Frances X. Cabrini School of Practical Nursing
811 S. Lytle St. 60607

DANVILLE
Danville School of Practical Nursing
200 E. Main 61832

DECATUR
Decatur School of Practical Nursing
210 W. North St. 62521

DE KALB
Kishwaukee School of Practical Nursing
612 Haish Blvd. 60115

DIXON
Sauk Valley College
River Campus Route #1 61021

EAST PEORIA
Illinois Central College Practical Nursing Program, Health Education
P.O. Box 2400 61611

EAST ST. LOUIS
School of Practical Nursing
910 Summit 62201

GALESBURG
Carl Sandburg College, Department of Practical Nursing
Box 1407, South Lake Storey Road 61401

GRAYSLAKE
Lake County College Practical Nurse Program
19315 Washington Street 60030

HARRISBURG
Southeastern Illinois College, School of Practical Nursing
333 W. Church St. 62946

HARVEY
Thornton Community College, Department of Practical Nursing
150th Broadway 60426

HINSDALE
Hinsdale Hospital School of Practical Nursing
120 N. Oak St. 60521

JACKSONVILLE
Jacksonville Board of Education School of Practical Nursing
504 E. Court St. 62650

JOLIET
Joliet Township H.S.
School of Practical Nursing
201 E. Jefferson St. 60432

KANKAKEE
Kankakee School of Practical Nursing
Kankakee Community College
Box 888 60901

LASALLE
St. Mary's Hospital
School of Practical Nursing
1015 O'Connor St. 61301

MATTOON
Lake Land College
School of Practical Nursing
1921 Richmond 61938

MOLINE
Black Hawk College
Practical Nursing Program
6600-34th Ave. 61265

MORTON GROVE
Oakton Community College
7900 N. Nagle 60053

MT. CARMEL
Wabash Valley College
Practical Nursing Program
2200 College Dr. 63863

MT. VERNON
Rend Lake College
Practical Nursing Program

PALATINE
William Rainey Harper
Practical Nursing Program
Algonquin & Roselle Roads 60067

QUINCY
Quincy School of Practical Nursing
820 Vermont Street 62301

RIVER GROVE
Triton Junior College
Practical Nursing Program
2000 N. Fifth Ave. 60171

ROCKFORD
Rockford School of Practical Nursing
201 S. Madison 61101

SPRINGFIELD
Springfield School of Practical Nursing
1101 S. 15th St. 62704

STREATOR
Streator Township High School
Practical Nurse Program
600 N. Jefferson 61364

ULLIN
Shawnee Community College
Department of Nursing
Shawnee College Road 62992

ILLINOIS STATE GOVERNMENT

The state government is divided into three branches—legislative, executive and judicial. The legislative power is vested in the General Assembly, which is composed of the State Senate and the House of Representatives (a bicameral assembly).

For representation in the General Assembly, there are 59 Legislative Districts. Each district elects one senator and three representatives. Thus, the Senate has 59 members and the House 177. The senators are elected for four-year terms, and the representatives serve two-year terms.

The General Assembly convenes in January of each year. The General Assembly's functions are to enact, amend, or repeal laws or adopt appropriation bills, act on amendments to the United States Constitution, and act to remove public officials.

When the House of Representatives is organized, a Speaker or presiding officer is elected for the biennium. The presiding officer of the Senate is the President of the Senate. To facilitate the handling of legislation, the members of the Senate and House are assigned to designated committees to consider bills of like subject matter. These committees usually hold public hearings to discuss legislation before the measure is taken up by the entire House or Senate. There are approximately 50 committees.

EXECUTIVE BRANCH

The Constitution provides that the Executive Department shall consist of the Governor, Lieutenant Governor, Secretary of State, Comptroller, Treasurer, and Attorney General. All of these officials are elected for four-year terms.

LEGISLATIVE BRANCH

Legislative Procedure

Each member of the General Assembly has the power to introduce bills or resolutions. When a bill is introduced it is read at large a first time, ordered printed, and referred to the proper committee for consideration, except that in case of an emergency, a bill may be advanced without reference to committee. If the committee recommends the bill favorably, it is sent to second reading when amendments to it can be offered for consideration by the entire membership. The bill will then be given a third and final reading when it is acted upon by the entire membership of the house that is considering it.

Action by Both Houses

To pass, the bill must receive the favorable vote of the majority of the members elected (89 in the House; 30 in the Senate). These bills are then sent to the other house where essentially the same procedure is followed.

If, because of amendments in the second house, there are two versions of the same bill, conference committees may be appointed to work out the differences. Both houses must vote favorably on the same version of the bill before it can be sent to the Governor for his consideration.

If the Governor thinks the bill should become a law, he will sign it. If the Governor decides it would be unwise for the bill to become law, he can veto it. If he vetoes the bill, he must file a statement of objections. Three-fifths of the members elected to each House can override the veto. He can also veto specific items of an appropriation bill and he may reduce an appropriation. The Governor may also return a bill to the Legislature with specific recommendations for change, thereby obviating the need of vetoing the entire bill.

NOTE

A Legislative Directory containing the names and addresses of all members of the Illinois General Assembly and the Illinois Senators and Representatives in the Congress is available. Requests should be directed to: Illinois State Medical Society, Regional Office, 520 S. Sixth St., Springfield, 62701.

STATE OFFICERS

Governor, RICHARD B. OGILVIE, Rep., Chicago
Lieutenant Governor, PAUL M. SIMON, Dem., Troy
Secretary of State, JOHN LEWIS, Rep., Marshall
Auditor of Public Accounts, MICHAEL J. HOWLETT, Dem., Chicago
State Treasurer, ALAN DIXON, Dem., Belleville
Attorney General, WILLIAM J. SCOTT, Rep., Evanston
Superintendent of Public Instruction, MICHAEL BAKALIS, Dem., DeKalb
Clerk of the Supreme Court, JUSTIN TAFT, Rep., Rochester

DEPARTMENT OF CHILDREN AND FAMILY SERVICES

Director's Office

524 South Second St., Springfield
Room 1713, 160 N. LaSalle St., Chicago
Jimi Anne Lawrence, *Director*
Merle E. Springer, Executive Deputy Director
Roman L. Haremski, Deputy Director, Program Services
Charles H. Sweeney, Deputy Director, Management Services
Richard S. Laymon, Administrative Asst. to the Director and Guardianship Administrator
Thomas A. Nickell, Administrative Asst. to the Director
Ronald A. Williams, Confidential Asst. to the Director
Joyce Bolinger, Special Asst. to the Director, Day Care
Frank Kopecky, Technical Advisor
J. Keller Mack, M.D., Medical and Public Health Officer

Office of Affirmative Action

Room 1713, 160 N. LaSalle St., Chicago
Robert N. Thayer, *Administrator*

Office of Community Relations

524 South Second St., Springfield
Donald H. Schlosser, *Administrator*

Office of Planning and Community Development

524 South Second St., Springfield
William H. Ireland, *Director of Planning*
Thomas E. Villiger, Administrator of Community Development

Division of Child Welfare

524 South Second St., Springfield
Richard J. Bond, *Director*
Walter R. McConner, Chief, Metropolitan Area
Ralph L. Hanebutt, Chief, Downstate Area

Regional and District Offices—

Aurora Operations (Leland Wright, Dir.), 361 Old Indian Trail
Aurora District, 361 Old Indian Trail
Joliet District, 257 Springfield Avenue
Kankakee District, Suite 110, 139 N. Dearborn
Waukegan District, 2550 N. Green Bay Road

Chicago Operations (Ralph J. Baur, Dir.), Rm. 326, 1439 S. Michigan Avenue
Central District, 1026 S. Damen Avenue
East District, 1439 S. Michigan Avenue
North District, 4320 W. Montrose Avenue
South District, 9718 S. Halsted Street
Special Services District, 1439 S. Michigan Avenue
Evelyn Edwards Emergency Child Care Center (Donald T. Hageman, Administrator), 2020 W. Roosevelt Road
Herrick House Children's Center (Thomas P. Brennan, Administrator), West Bartlett Road, Bartlett
Lawndale Day Care Center (Genevieve U. Barclay, Administrator), 2929 W. 19th Street
Woodlawn Early Childhood Development Center (Laura Tartt, Administrator), 950 E. 61st Street

Champaign Region (Thomas L. Tucker, Reg. Dir.), 2125 S. First St.
Champaign District, 2125 S. First St.
Bloomington District, 301 Prospect Road
Danville District, 110 E. Williams
Decatur District, 125 N. Franklin St.
Mattoon District, 1000 Broadway
Paris Office, 327 N. Main St.

East St. Louis Region (Jack M. Donahue, Reg. Dir.), Suite 109, 310 N. Tenth St.
East St. Louis District, 917 Illinois Ave.
Edwardsville District, 116 Hillsboro Ave.
Sparta Office, 121½ West Broadway Street
Maryville Temporary Child Care Facility, Maryville

Marion Region (E. Paul Nelson, Reg. Dir.), 2209 W. Main Street
Marion District, 2209 W. Main Street
Cairo Office, 529 Cross Street
Harrisburg Office, 219 S. Main Street
Metropolis Office, City National Bank Building, Fifth and Ferry Streets
Murphysboro District, 21 N. 11th Street
Olney District, 1108 S. West Street
Salem District, 205 E. Locust Street
Southern Illinois Children's Service Center (William F. Ayers, Administrator), Hurst

Peoria Region (Francis R. Paule, Reg. Dir.), 5415 N. University Ave.
Peoria District, 5415 N. University Ave.
Galesburg District, 121 S. Prairie St.
Moline District, 1805 Seventh St.
Ottawa District, 412 W. Madison St.
Galesburg Group Care Home, 1046 Grand Avenue

Rockford Region, (Margaret M. Kennedy, *Reg. Dir.*), 4302 N. Main St., P.O. Box 915
Rockford District, 4302 N. Main St., P.O. Box 915
Rock Falls District, 203½ First Ave.

Springfield Region (William W. Sanders, *Reg. Dir.*), Rm. 122, 4500 S. Sixth St. Rd.
Springfield District, Rm. 122, 4500 S. Sixth St. Rd.
Carlinville District, 494½ W. Side Square
Jacksonville District, 602 Westgate Ave.
Quincy District, 410 N. Ninth St.

Division of Educational and Rehabilitation Services

524 South Second St., Springfield
Lee A. Iverson, *Director*
Everett E. Hamilton, Funded Programs Consultant

Institutions—

Illinois Braille and Sight Saving School (Jack Hartong, Supt.), Jacksonville
Illinois Children's Hospital-School (Paul Kavanaugh, Supt.), 1950 W. Roosevelt Rd., Chicago
Illinois School for the Deaf (Kenneth Mangan, Supt.), Jacksonville
Illinois Soldiers' and Sailors' Children's School (Andrew Spelios, Supt.), Normal
Illinois Soldiers' and Sailors' Home (Richard Northern, Supt.), Quincy
Illinois Visually Handicapped Institute (Thomas Murphy, Supt.), 1151 S. Wood St., Chicago

Visually Handicapped Services—

Community Services for the Visually Handicapped (I. N. Miller, Supt.), Rm. 1700, 160 N. LaSalle St., Chicago

Except for Cook County, field offices for this program are located in the Department's regional offices. See listings under Division of Child Welfare.

Division of Financial Management

524 South Second St., Springfield
Matthew J. Finnell, Chief

Division of Methods and Information Services

524 South Second St., Springfield
August G. Egger, Jr., Chief

Division of Administrative Services

524 South Second St., Springfield
Carlos Gwin, Chief
Robert W. Gorman, Administrator, Procedural and Management Audit

Division of Personnel Administration

524 South Second St., Springfield
Alex J. Jones, Chief Personnel Officer

DEPARTMENT OF MENTAL HEALTH

401 S. Spring St., Springfield, 62706
160 N. La Salle St., Chicago, 60601

Office of the Director

Albert J. Glass, M.D., *Director*
Victoria Smaller, Administrative Assistant
Robert E. Lanier, Special Assistant
Robert Y. Anderson, Special Assistant

Audits

George Skadden, Auditor

Research & Development

Peter K. Levison, Ph.D., Manager

Training

Matthew Parrish, M.D. Manager

Division of Legislative Liaison

H. Dickson Buckley, Manager

Division of Legal Services

Jerome Goldberg, Manager

Management Group

C. R. Crawford, Administrator

Division of Financial Management

Carlton Jencks, Manager

Division of Information Systems

Stephen Andersen, Manager

Field Division, Mental Health, Department of Personnel

John Meyer, Chief Personnel Officer

Special Programs

Drug Abuse Programs
Edward C. Senay, M.D., Director
Alcoholism Programs
James T. Griffin, Advisor
Physical Education, Activity and Recreation
L. Hopkins, Advisor
Children's and Adolescents' Programs
Gerald Kissin, Ph.D., Advisor
Facilities and Program Standardization
Joseph Saxl, Advisor
Communications
David R. Ganfield, Advisor

Regions and Institutions

1A (ROCKFORD): Donald W. Hart, Administrator, H. Douglas Singer Zone Center, 4402 N. Main St., Rockford 61103
H. DOUGLAS SINGER ZONE CENTER: William G. Smith, M.D., Superintendent, Rockford 61103

1B (PEORIA): James Ward, M.D., Administrator, George A. Zeller Zone Center, 5407 N. University, Peoria 61614
GEORGE A. ZELLER ZONE CENTER, James Ward, M.D., Superintendent, Peoria 61614
EAST MOLINE STATE HOSPITAL: Konstantin Dimitri, M.D., Superintendent, East Moline 61244
GALESBURG STATE RESEARCH HOSPITAL: Angelo Zocchi, M.D., Acting Superintendent, Galesburg 61401
PEORIA STATE HOSPITAL: Henry D. Staras, M.D., Superintendent, Peoria 61607

2 (CHICAGO): Patrick R. Staunton, M.D., Administrator, 232 E. Ohio St., Chicago 60611
CHICAGO-READ MENTAL HEALTH CENTER: John Nelson, M.D., Superintendent, 6500 W. Irving Park Rd., Chicago 60634
JOHN J. MADDEN MENTAL HEALTH CENTER: Robert deVito, M.D., Superintendent, 1200 S. First Ave., Hines 60141
ELGIN STATE HOSPITAL: Robert J. Mackie, M.D., Superintendent, Elgin 60120
KANKAKEE STATE HOSPITAL: Gabriel Misevic, M.D., Superintendent, Kankakee 60901
MANTENO STATE HOSPITAL: John R. Collier, Superintendent, Manteno 60950
TINLEY PARK MENTAL HEALTH CENTER: H. C. Piepenbrink, Superintendent, Tinley Park 60477

3A (SPRINGFIELD): William H. Anderson, M.D., Administrator, Andrew McFarland Zone Center, 901 Southwind Road, Springfield 62703
ANDREW McFARLAND ZONE CENTER: Martin Cohen, Ph.D., Superintendent, Springfield 62703
JACKSONVILLE STATE HOSPITAL: Andrew L. Hoekstra, M.D., Superintendent, Jacksonville 62650

3B (DECATUR-CHAMPAIGN): Lewis Kurke, M.D., Administrator, Adolf Meyer Zone Center, East Mound Rd., Decatur 62526
ADOLF MEYER ZONE CENTER (Adults): Lewis Kurke, M.D., Acting Superintendent, Decatur 62526

HERMAN M. ADLER ZONE CENTER (Children); J. Gregory Langan, Ed.D., Superintendent, 2204 Griffith Dr., Champaign 61820

4 (EAST ST. LOUIS): Ivan Pavkovic, M.D., Administrator, Alton State Hospital, 4500 College Ave., Alton 62002

ALTON STATE HOSPITAL: Endré Komlos, M.D., Medical Director; Jos. Gruber, Admin. Director, Alton 62002

ILLINOIS SECURITY HOSPITAL: Vernon J. Uffelman, Superintendent, Chester 62233

5 (CARBONDALE): Robert C. Steck, M.D., Administrator, Anna State Hospital, Anna 62906

ILLINOIS MENTAL HEALTH INSTITUTES: Lester H. Rudy, M.D., Administrator, 1601 W. Taylor St., Chicago 60612

INSTITUTE FOR JUVENILE RESEARCH: Frank T. Rafferty, M.D., Director, 907 S. Wolcott St., Chicago 60612

ILLINOIS STATE PEDIATRIC INSTITUTE: Herbert J. Grossman, M.D., Director, 1601 W. Taylor St., Chicago 60612

ILLINOIS STATE PSYCHIATRIC INSTITUTE: Lester H. Rudy, M.D., Director, 1601 W. Taylor St., Chicago 60612

Division of Mental Retardation Services

William Sloan, Ph.D., Administrator, Springfield 62706
Charles R. Meeker, Assistant Administrator
Charles Jubenville, Ed.D., Assistant Administrator
Richard Blanton, Ph.D., Deputy Administrator
Christian Simonson, Assistant Administrator
Eugene Kelly, Assistant Administrator
A. L. BOWEN CHILDREN'S CENTER: A. J. Shafter, Ph.D., Superintendent, Harrisburg 62946
DIXON STATE SCHOOL: David Edelson, Superintendent, Dixon 61021
WILLIAM W. FOX CHILDREN'S CENTER: Thomas P. Crane, M.D., Superintendent, Dwight 60420
LINCOLN STATE SCHOOL: Lawrence Bussard, Superintendent, Lincoln 62656
ELISABETH LUDEMAN CENTER: Fred A. McCormack, Superintendent, Park Forest 60466
WARREN G. MURRAY CHILDREN'S CENTER: Walter Plassman, M.D., Superintendent, Centralia 62801

STATUTORY BOARDS AND COUNCILS

1. Mental Health Commission

Honorable Esther Saperstein, Chicago, *Chairman*
Honorable Charles J. Fleck, Jr., Chicago, *Vice-Chairman*
Honorable Frank M. Ozinga, Evergreen Park, Executive Secretary
Honorable Daniel P. O'Brien, Jr., Chicago
Honorable E. J. "Zeke" Giorgi, Rockford
Honorable Michael F. Zlatnik, Chicago
John L. Cutter, M.D., Evergreen Park
Mrs. Elizabeth Ferry, Decatur
Edward J. Copeland, Chicago
Ex Officio—Albert J. Glass, M.D., Director, Department of Mental Health

2. Mental Health Planning Board

Mrs. Alice B. Ihrig, Oak Lawn, *Chairman*
Donald J. Caseley, M.D., Chicago
Harlan English, M.D., Danville
LeRoy Levitt, M.D., Chicago
Donald Moss, Chicago
Ray Moss, Clinton
John Parkhurst, Peoria
John R. Schuerman, Ph.D., Chicago
Brockman Schumacher, Ph.D., Carbondale
Honorable Robert S. Juckett, Sr., Park Ridge
Honorable Howard R. Mohr, Forest Park
Honorable Esther Saperstein, Chicago
Honorable Anthony Scariano, Chicago Heights
Ex Officio:
William H. Ireland (Chairman, Council of State and Federal Agencies), Springfield
Judith S. Schild, CSW, ACSW (Chairman, Council of Professional Societies), Chicago
Jerome Winer, M.D. (Chairman, Council of Universities), Chicago
Albert J. Glass, M.D. (Director, Department of Mental Health) Chicago
Mrs. Hazel Blumenthal, Executive Secretary

3. Board of Reimbursement Appeals

(vacant)
Harold Meitus, Chicago
Richard L. Thies, Urbana

4. Psychiatric Advisory Council

Roy R. Grinker, Sr., M.D., Chicago, *Chairman*
H. H. Garner, M.D., Chicago *Vice-Chairman*
George Pollock, M.D., Chicago
Melvin Sabshin, M.D., Chicago
Lester H. Rudy, M.D., Chicago
Jackson Smith, M.D., Hines
Harold M. Visotsky, M.D., Chicago
Ex Officio—Albert J. Glass, M.D., Director, Department of Mental Health

5. Advisory Council —PL 88-164—Construction Grants

Roy R. Grinker, Sr., M.D., Chicago, *Chairman*
Franklin D. Yoder, M.D., Springfield
Mrs. Jimi Ann Lawrence, Springfield
Edward T. Weaver, Springfield
Alfred Slicer, Chicago
David Donald, Springfield
Henry S. Monroe, Winnetka
George K. Hendrix, Springfield
David M. Kinzer, Chicago
Hiram Sibley, Chicago
Mrs. Bernice T. Van der Vries, Evanston
Robert A. Henderson, Ed.D., Urbana
Donald J. Caseley, M.D., Chicago
Donald H. Moss, Chicago
Mrs. John T. Even, Aurora
E. D. Stoetzel, Washington
Very Rev. Msgr. James V. Moscow, Chicago
Mrs. Elbert Tourangeau, Hinsdale
John H. Geiger, Des Plaines
Thomas J. Nayder, Chicago

NON-STATUTORY BOARDS AND COUNCILS

1. Alcoholism Advisory Board

George Tim Herrmann, Chicago, *Chairman*
James H. Oughton, Jr., Dwight, *Vice-Chairman*
James West, M.D., Evergreen Park
Nelson Bradley, M.D., Park Ridge
The Rt. Rev. Msgr. Ignatius McDermott, Chicago
The Honorable Henry W. McGee, Chicago
Paul B. Musgrove, Peoria
Richard M. Sanders, Ph.D., Carbondale
Stephen J. Foxx, Chicago
Lou Presnall, Chicago
George W. Erdmann, Arlington Hts.
Mrs. Jean Alice Small, Kankakee

2. Advisory Committee on Community Mental Health Grants

Vernon Frazee, Ed.D., Morton Grove, *Chairman*
Downstate Sub-Committee:
Mrs. Joseph Lickfield, Peoria
Msgr. William J. Cassin, Springfield
John Chapin, Springfield
Kenneth Etchcson, Canton
Mrs. Elaine Hoff, Springfield
Mrs. Sara Kessler, Decatur
Fred H. Kimbrough, East St. Louis
Groves B. Smith, M.D., Alton
Northern Illinois Sub-Committee:
Vernon Frazee, Ed.D., Morton Grove
Mrs. Ruth Bateman, Warrenville
Honorable Seely P. Forbes, Rockford
Arnold Levin Homewood
Mrs. Gordon L. Monsen, Barrington
Donald H. Moss, Chicago
Mrs. Eleanor Price, DeKalb
Mrs. Vivian Wright, Aurora
City of Chicago Sub-Committee:
Robert Farwell, Chicago
Albert Bonilla, Chicago
Mrs. Faye Katzen, Chicago
Mrs. June B. McNally, Chicago
Samuel A. Patch, Chicago
Thomas Smith, Chicago
Samuel Weingarten, Ph.D., Chicago

3. Dangerous Drugs Advisory Council

Albert J. Glass, M.D., Chicago, *Chairman*
Joseph H. Skom, M.D., Chicago, *Vice-Chairman*
Honorable Arthur A. Telcser, Chicago
Honorable John Merlo, Chicago
Honorable David C. Shapiro, M.D., Amboy
Honorable Charles Chew, Jr., Chicago
Honorable Terrel E. Clarke, Western Springs
Honorable Ben E. Palmer, Chicago
Herbert D. Brown, Springfield
Franklin D. Yoder, M.D., Springfield
Alfred Slicer, Springfield
Judge Kenneth Wendt, Chicago
Peter B. Bensinger, Springfield
Mrs. Jimi Ann Lawrence, Springfield
Edward C. Senay, M.D., Chicago
Michael Bakalis, Springfield
Edward V. Hanrahan, Chicago
James B. Conlisk, Jr., Chicago
Commissioner Murray C. Brown, M.D., Chicago
Kermit T. Mehlinger, M.D., Chicago
Daniel X. Freedman, M.D., Chicago
David B. Blumenfeld, Chicago
Mrs. Ralph Falk, II, Chicago
Robert C. Strodel, Esq., Peoria
Richard S. Gliebe, Chicago
George W. Woodcock, Mt. Carmel
Herman Lancaster, Executive Secretary
James Moran, Secretary

DEPARTMENT OF PUBLIC AID

The Illinois Department of Public Aid administers the federally aided public assistance programs: Assistance to the Aged, Blind or Disabled; Aid to Dependent Children; and Medical Assistance. In addition, the department allocates state funds to qualified governmental units for the administration of General Assistance; and in cooperation with the United States Department of Agriculture, administers the Food Stamp program.

Administrative Staff

Edward T. Weaver, *Director*
David M. Bankard, *Deputy Director*
James M. Brown, *Deputy Director*
Verne H. Evans, Executive Assistant and General Counsel
Bruce Flashner, M.D., Medical Director, Division of Medical Services
Norman Ryan, Chief, Division of Accounting
Louis J. Giordano, Chief, Division of Administrative Services
William M. Fishback, Chief, Division of County Operations
Arthur C. Zimmerman, Chief, Division of Investigation and Enforcement
Robert G. Wessel, Chief, Medical Administration, Division of Medical Services
Bruce Ferguson, Chief, Division of Methods and Data Services
Jesse B. Harris, Chief, Division of Policy and Procedures
Wayne D. Epperson, Chief, Division of Research and Statistics
Barbara J Wright, Chief, Office of Public Information
Fred Z. Weiss, Chief, Office of Services for the Aging
Robert Benson, Jr., office of Social Services and Planning
William Harrison, Operations Research

Regional Offices

Region IA—Rockford	Reno L. Lenz Regional Director
Region IB—Peoria	Frank G. Blumb Regional Director
Region 2—Elgin	Eugene R. Muffler Regional Director
Region 3A—Springfield	Charles H. Pfotenhauer Regional Director
Region 3B—Champaign	Ora M. Wilson Regional Director
Region 4—Belleville	Armin A. Rippelmeyer Regional Director
Region 5—Marion	Lawrence E. Duff Regional Director

Legislative Advisory Committee on Public Aid

The Honorable John W. Carroll, Park Ridge, *Chairman*
The Honorable Meade Baltz, Joliet
The Honorable Charles M. Campbell, Danville
The Honorable Roscoe Cunningham, Lawrenceville
The Honorable Corneal A. Davis, Chicago
The Honorable Daniel Dougherty, Chicago
The Honorable Monroe L. Flinn, Cahokia
The Honorable Egbert B. Groen, Pekin
The Honorable Robert E. Mann, Chicago
The Honorable Don. A. Moore, Midlothian
The Honorable Esther Saperstein, Chicago
The Honorable Fred J. Smith, Chicago

Medical Care Advisory Committee

John J. Byrne, D.D.S., Chicago
Murray H. Finley, Chicago
Mrs. Mary L. Ford, Chicago
Chauncey C. Maher, Jr., M.D., Springfield
B. E. Montgomery, M.D., Harrisburg
Robert C. Muehrcke, M.D., Oak Park
Harold W. Pratt, R.Ph., Chicago
Morton Sabath, Springfield

Ex-Officio Members

Albert J. Glass, Director, Department of Mental Health, Springfield
Edward F. Lis, M.D., Director, Division of Services for Crippled Children, University of Illinois College of Medicine, Chicago
Alfred Slicer, Director, Division of Vocational Rehabilitation, Springfield
Edward T. Weaver, Director, Department of Public Aid, Springfield
Franklin D. Yoder, M.D., M.P.H., Director, Department of Public Health, Springfield

Department of Public Aid Representatives

Bruce Flashner, M.D., Medical Director, Division of Medical Services
Robert G. Wessel, Chief, Medical Administration, Division of Medical Services

State Medical Advisory Committee

Louis Arp, Jr., M.D., Moline
James R. Cooper, M.D., Quincy
Edsel K. Hudson, M.D., Chicago
Frank J. Jirka Jr., M.D., River Forest
Paul F. LaFata, M.D., Springfield
George F. Lull, M.D., Chicago
George T. Mitchell, M.D., Marshall
Robert C. Muehrcke, M.D., Oak Park
Jacob E. Reisch, M.D., Springfield
Alphonso L. Robinson, M.D., Mounds
Philip G. Thomsen, M.D., Dolton
Fred A. Tworoger, M.D., Chicago

State Drug Advisory Committee

W. Edwin Brown, R.Ph., Quincy
Carl V. Daschka, R.Ph., Chester
H. M. F. Doden, Sr., R.Ph., Rock Island
Justin Eisele, R.Ph., East St. Louis
Louis Gdalman, R.Ph., Chicago
John T. Gulick, R.Ph., Danville
John F. Koller, R.Ph., Berwyn
Roy B. Maher, R.Ph., Springfield
Harold W. Pratt, R.Ph., Northbrook
Theodore R. Sherrod, M.D., Ph.D., Chicago
Harold J. Shinnick, R.Ph., Chicago
Charles P. Skaggs, R.Ph., Harrisburg

State Dental Advisory Committee

John C. Barrett, D.D.S., Freeport
John J. Byrne, D.D.S., Chicago
Vernon J. Haas, D.D.S., Bloomington
Robert B. Jans, D.D.S., Evanston
D. J. McCullough, D.D.S., Wayne City
H. B. Riley, D.D.S., Newton
William J. Rogers, D.D.S., Chicago
Carl L. Sebelius, D.D.S., Springfield
Harold H. Sitron, D.D.S., Chicago

State Advisory Committee on Group Care Facilities

Don T. Barry, Raymond
Joseph Bonnan, Chicago
Taylor O. Braswell, Belleville
Bert Cohn, Okawville
Mrs. Rachel Dodson, Herrin
Edward Farmilant, Chicago
William K. Ford, M.D., Rockford
Thomas Frey, Chicago
Markham D. Hay, Rockford
Elmer Johnson, Joliet
Mrs. Laverta Johnson, Chicago
Robert E. Lanier, Springfield
Roger F. Sondag, M.D., M.P.H., Springfield
Albert Teaters, Charleston

Department of Public Aid Staff Members

Edward T. Weaver, Director
Robert G. Wessel, Chief, Medical Administrator
Patrick F. Kain, Supervisor, Central Medical Services

State Opticians Advisory Committee

James Conlon, Chicago
H. V. Jones, Champaign
Louis R. Long, Springfield
Edwin A. Moll, Chicago
John M. Noel, O.D., E. St. Louis
Gene Schanbaum, O.D., Chicago
George N. Schoonover, Chicago

State Optometric Advisory Committee

Albert A. Bucar, O.D., Antioch
Henry J. Luckhardt, O.D., Westmont
Stanley F. Maer, O.D., Granite City
Henry R. Moore, O.D., Chicago
Paul F. Shulman, O.D., Chicago
J. B. Stafford, O.D., Peoria

State Podiatry Advisory Committee

John T. Baldwin, D.P.M., Kankakee
Fred G. Broun, D.P.M., Oak Park
Leonard Burroughs, D.P.M., Chicago
James T. Burton, D.P.M., Springfield
William J. Frisch, D.P.M., Freeport
Clifford F. Malcolm, D.P.M., Mt. Carmel
O. A. Mercado, D.P.M., Chicago
C. J. Meyer, D.P.M., Macomb
Genelle B. Smith, D.P.M., Belleville

DEPARTMENT OF PUBLIC HEALTH

535 West Jefferson St., Springfield 62706
Franklin D. Yoder, M.D., M.P.H., *Director*
Bruce A. Flashner, M.D., Deputy Director
E. L. Wittenborn, M.P.H., Assistant to the Director
R. F. Sondag, M.D., M.P.H., Medical Assistant to Director

Office of Program Planning

Stephen N. Root, Chief

Bureau of General Administration

E. L. Wittenborn, M.P.H., Chief
Jesse Pride, Internal Auditor

Division of Administration

L. A. Kutilek, Chief
General Services
Mail Service
Vital Records

Division of Budget and Fiscal Operations

Walter E. DeWeese, Chief

Division of Data Processing

Thomas Stuckey, Chief

Division of Education and Information

Stanley Miles, Chief

Division of Local Health Administration

Charles F. Sutton, M.D., M.P.H., Chief

Division of Personnel

Gary Ey, Chief

Division of Public Health Laboratory

Richard A. Morrissey, M.P.H., Chief

Bureau of Personal and Community Health

Bruce A. Flashner, M.D. Chief

First Aid Stations:

Centennial Building
Third Floor, Capitol Building
First Floor, Highway Building

Division of Dental Health

Carl L. Sebelius, D.D.S., M.P.H., Chief

Division of Disease Control

Byron J. Francis, M.D., Chief
Epidemiology
Poison Control
Veterinary Medicine
Tuberculosis Control

Division of Emergency Medical Services and Highway Safety

David R. Boyd, M.D., Chief

Division of Family Health

James P. Paulissen, M.D., M.P.H., Chief
School Health

Division of Health Facilities

Paul X. Elbow, M.S.H.A., Chief

Division of Nursing

Helen M. Bruening, R.N., M.P.H., Chief

Bureau of Environmental Health

Verdun Randolph, M.P.H., Chief

Division of Food and Drugs

Roy W. Upham, D.V.M., M.S., Chief

Division of General Sanitation

James Yallaly, B.S., Chief
Migrant Labor
Plumbing Contractors
Private Water and Sewage
Trailer Parks
Vector Control and Pesticides
Well-Pump Codes

Division of Milk Control

Harold McAvoy, Acting Chief

Division of Radiological Health

Philip N. Brunner, M.S., Chief

Division of Swimming Pools and Recreation Camps

Jerry Ackerman, B.S., Chief

Branch Offices

Region IA

4302 North Main, Rockford 61103

Region IB

5145 North University, Peoria 61614

Region IIA

48 West Galena Blvd., Aurora 60504

Region IIB

Chicago Hospital & Clinics, 1919 West Taylor
Chicago, Illinois 60612

Region IIIA

Room 173, Regional Office Building, 4500 South Sixth Street, Springfield 62706

Region IIIB

2125 South First St., Champaign 61820

Region IV

9500 Collinsville Rd., Unit E, Collinsville 62234

Region V

2209 West Main, Marion 62959

Branch Laboratories

Springfield Diagnostic Laboratory
134 N. Ninth St., Springfield 62706
Carbondale Laboratory
Oakland & Chautauqua Sts., Carbondale 62901

LOCAL HEALTH DEPARTMENTS

Adams County Health Department
Gene Mann, M.P.H., Public Health Administrator,
333 North Sixth Street, Quincy, 62301

*Bond County Health Department
Carole Bone, R.N., Acting Administrator
107 W. College, Greenville, 62246

*Calhoun County Health Department
Mrs. Margaret Hillen, R.N., Acting Administrator
Hardin, 62047

*Carroll County Health Department
Acting Administrator
Court House, Mt. Carroll, 61053

*Christian County Health Department
Clara J. Beaty, R.N., Acting Administrator
Court House, Taylorville, 62568

*Clay County Health Department
Mrs. Patricia L. Borah, R.N., Acting Administrator
104½ West Second Street, Flora, 62839

Cook County Department of Public Health
John B. Hall, M.D., M.P.H., Director
1425 South Racine Avenue, Chicago, 60608

District Offices:

North—DesPlaines
South—Harvey
Southwest—Oak Lawn
West—Melrose Park

*DeKalb County Health Department
Mrs. Mattie Millen, R.N., Public Health Administrator
1731 Sycamore Road, DeKalb, 60115

DeWitt-Piatt Bi-County Health Department
Ruth Gregor, R.N., Acting Administrator
122 East Main Street, Clinton, 61727
Piatt County Office:
Court House, Monticello 61856

*Douglas County Health Department
Mrs. Evelyn Henderson, R.N., Acting Administrator
County Court House, Tuscola, 61953

DuPage County Health Department
Charles A. Lang, M.D., M.P.H., Health Officer
222 East Willow Avenue, Wheaton, 60187

Effingham County Health Department
Peter C. Supan, M.D., M.P.H., Health Officer
112 East Section Avenue, Effiingham, 62401

Egyptian Health Department
Allen Kelly B.S., Public Health Administrator
1333 Locust Street, Eldorado, 62930
County Offices:
White County—Carmi, 62821
Gallatin County—Court House, Shawneetown, 62984

Franklin-Williamson Bi-County Health Department
Charles W. Elder, D.D.S., Public Health Administrator
217 East Broadway, Johnston City, 62951
Franklin County Office:
226 North Main, Benton, 62812

Fulton County Health Department
A. James Masters, M.P.H., Public Health Administrator
31 South Main Street, Canton, 61520

*Greene County Health Department
Mrs. Barbara Cook, R.N., Acting Administrator
229 North Fifth Street, Carrollton, 62016

*Grundy County Health Department
Mrs. Mary C. Reed, R.N., B.S., Public Health Admin.
1340 Edwards Street, Morris, 60540

*Henry County Health Department
Grace Van Vooren, R.N., Acting Administrator
Court House Annex, Cambridge, 61238

*Iroquois County Health Department
Mrs. Nancy Tucker, R.N., Acting Administrator
County Court House, Watseka, 60970

Jackson County Health Department
John B. Amadio, Ph.D., Public Health Administrator
342A North Street, Murphysboro, 62966

*Jersey County Health Department
Mrs. Nola Kramer, R.N., Acting Administrator
301 S. Jefferson, P.O. Box 69

JoDaviess County Health Department
Dan Bain, M.P.H., Public Health Administrator
311 South Main Street, Galena, 61036

*Kendall County Health Department
Ruth Ann Little, R.N., Acting Administrator
203 Fox Road, Yorkville, 60560

Lake County Health Department
Jack I. Smith, M.D., Dr. P.H., Director
1515 Washington Street, Waukegan, 60085

Lawrence County Health Department
Maxine Jackman, R.N., Public Health Administrator
Court House, Lawrenceville, 62439

Lee County Health Department
E. S. Parmenter, M.D., Health Officer

**With Limited Services*

413 E. First St., Dixon, 61021
*Livingston County Health Department
Mrs. Gladys Kohrt, R.N., Acting Administrator
R.R. 4, Convalescent Center Building, Pontiac, 61764
*Logan County Health Department
Elizabeth Leif, M.P.H., Public Health Administrator
315 Eighth Street, Lincoln, 62656
*McHenry County Health Department
Richard A. Wissell, M.P.H., Public Health Administrator
209 North Benton Street, Woodstock, 60098
McLean County Health Department
E. E. Diddams, M.S.P.H., Public Health Administrator
401 West Virginia Avenue, Normal, 61761
Macon County Health Department
Leo Michl, Jr., M.S., Public Health Administrator
1085 South Main Street, Decatur, 62521
*Menard County Health Department
Mrs. Marjorie White, R.N., Acting Administrator
121 E. Douglas, Petersburg, 62675
*Monroe County Health Department
Mrs. Mary Kruse, R.N., Acting Administrator
224 E. 3rd Street, Waterloo, 62298
Montgomery County Health Department
C Tom Larson, B.S. M.H.A., Public Health Administrator
433 South Main Street, Hillsboro, 62049
Morgan County Health Department
William D. Meyer, B.S., Acting Administrator
234½ West State Street, Jacksonville, 62650
*Ogle County Health Department
106 South Fifth Street, Oregon, 61061
Peoria County Health Department
Harold H. Rohrer, M.D., M.P.H., Director
2114 North Sheridan Road, Peoria, 61604
*Pike County Health Department
Mrs. Martha Lowry, R.N., Acting Administrator
216 North Monroe, Pittsfield, 62362
Quadri-County Health Department
William Hensley, Acting Administrator
Golconda, 62938
Massac County Office:
Court House, Metropolis, 62960
Johnson County Office:
Vienna, 62995
Hardin County Office:
Gross Building, Elizabethtown, 62931
*Randolph County Health Department
Mrs. Marilynn Murphy, R.N., B.A., Acting Administrator
110 West Jackson Street, Sparta, 62286
*Rock Island County Health Department
Fred J. Siebenmann, Jr., B.S., Public Health Admin.
County Office Building, Rock Island, 61201
Shelby County Health Department
Peter C. Supan, M.D., M.P.H., Health Officer
123 North Broadway, Shelbyville, 62565
*Stephenson County Health Department
Mrs. Fern Brown, R.N., Acting Administrator
12 North Galena Avenue, Freeport, 61032
Tazewell County Health Department
Gordon J. Poquette, M.P.H., Public Health Administrator
1505 Valle Vista, Pekin, 61554

Tri-County Health Department
Ralph K. Gibson, R.P.E., Public Health Administrator
529 Cross Street, Cairo, 62914
Union County Office:
Jonesboro, 62952

*Vermilion County Health Department
Gale Fella, B.S., M.P.H., Public Health Administrator
808 North Logan, Danville, 61832

*Wabash County Health Department
Mrs. Dorothy Munro, R.N., Acting Administrator
Court House, Mt. Carmel, 62862
*Whiteside County Health Department
Mrs. Ramona Stene, R.N., Acting Administrator
201 West First Street, Rock Falls, 61071
Will County Health Department
Herbert S. Miller, M.D., M.P.H., Health Officer
501 Ella Avenue, Joliet, 60433
Winnebago County Department of Public Health
Joseph Orthoefer, D.V.M., P. H. Administrator
401 Division St., Rockford, 61108

Berwyn Health Department
J. V. Pelech, M.D., Health Director
6600 West 26th Street, Berwyn, 60402

**Champaign-Urbana Public Health District
Richard Grabher, M.P.H., Public Health Administrator
505 South Fifth Street, Champaign, 61820

Chicago Board of Health
Murray C. Brown, M.D., Commissioner of Health
Chicago Civic Center, Room 219, Chicago, 60602

**East Side Health District
Mani K. Sashankar, M.D., Dr.P.H., Public Health Director
638 North 20th Street, East St. Louis, 62205

Evanston-North Shore Health Department
Allan A. Filek, M.D., M.S.P.H., Public Health Director
1806 Maple Avenue, Evanston, 60201

Hygienic Institute
Arlington Ailes, M.D., M.P.H., Director
LaSalle, 61301

Oak Park Department of Public Health
Herbert Ratner, M.D., Public Health Director
129 Lake Street, Oak Park, 60302

Peoria Department of Health
Harold H. Rohrer, M.D., M.PH., Director
2116 North Sheridan Road, Peoria, 61604

Skokie Health Department
Samuel L. Adelman, M.D., M.P.H., Director of Health
8031 Floral Street, Skokie, 60076

**Stickney Township Public Health District
Gene J. Franchi, D.D.S., M.P.H., Acting P. H. Director
5635 State Road, Burbank, P.O. 60459

**with limited services*
***Organized under the Coleman Act*

STATUTORY BOARDS AND COMMISSIONS
(Allied with Public Health Operations)

Advisory Board of Necropsy Service to Coroners

Grant C. Johnson, M.D., Springfield, *Chairman*
Rep. Bernard McDevitt, Chicago
Jacob E. Reisch, M.D., Springfield
James Ryan, M.D., Kankakee
W. E. (Barney) West, Tamaroa
Guy R. Williams, Jr., Havana
Roger B. Ytterberg, Springfield
Horace H. Payton, Peoria

Long Term Care Facilities Advisory

Franklin D. Yoder, M.D., Springfield, *Chairman*
Joseph Patton, Springfield
Robert Wessel, Springfield
Larry E. Klapmeier, DeKalb
Stanley Palutsis, M.D., Riverside
Bertram Moss, M.D., Chicago
Steven Sargent, Springfield
Juanita Lott, R.N., Chicago
Joseph P. Welch, Barrington
John H. Coggeshall, Belleville
Taylor O. Braswell, Belleville
C. R. White, Carbondale
Lee L. Harvey, East St. Louis
Charles W. Beyer, Peoria

Illinois Advisory Committee on Hazardous Substances

Byron J. Francis, M.D., *Chairman,* Springfield
Robert S. Gleason, Springfield
Edward F. O'Toole, Chicago
Thomas Russell, Chicago
R. A. Didriksen, Missouri
Ben Studnicka, Woodstock
Robert M. Stansel, Park Ridge
H. LeRoy Richards, Racine, Wis.
G. Robert Sido, St. Louis, Mo.
Albert F. Limberg, Chicago

Advisory Hospital Council

Franklin D. Yoder, M.D., Springfield, *Chairman*
Representatives of Public Agencies
Robert E. Lanier, Springfield (Mental Health)
Robert G. Wessel, Springfield (Public Aid)
Rev. John Weishar, Peoria
John W. Rice, Olney
David M. Kinzer, Chicago
George K. Hendrix, Springfield
Robert Magnuson, Elmhurst
David S. Forkosh, M.D., Evanston
Francis Bihss, M.D., East St. Louis
Edward C. Thompson, D.D.S., Urbana
Daniel K. Bloomfield, Urbana
Willard C. Scrivner, M.D., Belleville
Hiram Sibley, Chicago
Mrs. William Hewitt, Rock Island
Roger N. White, Chicago
Mrs. Nancy B. Jefferson, Chicago
Mrs. William Carey, Evanston
Miss Margaret Cassin, East St. Louis
Charles T. Bell, Carthage
Mrs. Naomi Rowe, Chicago
Lee Pravatiner, Chicago

Clinical Laboratory and Blood Bank Advisory Board

Hugh J. McDonald, Sc.D., Skokie
D. Robert Thornburg, Wilmette
Grant C. Johnson, M.D., Springfield

Hospital Licensing Board

George K. Hendrix, Springfield, *Chairman*
William Lees, M.D., Lincolnwood
Elmer E. Abrahamson, Chicago
Jack B. Edmundson, Carbondale
F. Merrill Lindsay, Jr., Decatur
Rt. Rev. Msgr. Clement Schindler, Belleville
Emil O. Stahlhut, Lincoln
V. P. Siegel, M.D., East St. Louis

Board of Public Health Advisors

E. A. Piszczek, M.D., Forest Park, *Chairman*
Elmer Beadles, D.D.S., Ashland
Bernard E. Bolotoff, M.D., Rockford
Carl A. Brandy, D.V.M., Urbana
August F. Daro, M.D., Chicago
Robert G. Kesel, D.D.S., Chicago
Mrs. F. W. Specht, Wheaton
Alex Van Praag, Decatur

Migrant Labor Advisory Committee

Harold Hartley, Centralia
Miss Naomi Hiett, Springfield
W. D. Jones, Streator
Walter S. Sass, Chicago
Dean Sears, Bloomington
Blaine Ramsey, Springfield
Robert Munoz, Chicago
Gary Granby, Verona
David Villareal, Rock Island
Helen Kaufmann, R.N., Hoopeston

Ohio River Valley Water Sanitation Commission

Clarence W. Klassen, Springfield
Franklin D. Yoder, M.D., Springfield
John E. Pearson, Champaign

Radiation Protection Advisory Council

Howard Burkhead, M.D., *Chairman,* Evanston
Larry Lanzl, Ph.D., Chicago
Dr. Norman O. Nesheim, Springfield
Jerome J. Steerman, Urbana
Kenneth H. Schnepp, M.D., Springfield

Seymour Yale, D.D.S., Chicago
F. E. Demaree, Chicago, Barney J. Grabiec, *Ex Officio,* Chicago
David H. Armstrong, *Ex Officio,* Springfield

Illinois Chronic Renal Disease Advisory Committee

Franklin D. Yoder, M.D., Springfield, *Chairman*
Arthur E. Abney, Chicago
Allan A. Filek, M.D., Evanston
Henry P. Banser, Jr., Addison
Richard P. Demers, Chicago
David P. Earle, M.D., Chicago
Alan Kanter, M.D., Chicago
Robert M. Kark, M.D., Chicago
Rev. Beryl Kinser, Springfield
James D. Myers, M.D., Peoria
Franklin D. Schwartz, M.D., Chicago
George Dunea, M.D., Chicago
EX-OFFICIO MEMBERS:
Roy W. Brooks, Springfield
Bruce A. Flashner, M.D., Springfield
Anita Stoeppel, R.N., Chicago
A. R. Lavender, M.D., Hines

Immunization Advisory Committee

John B. Hall, M.D. Chicago
Joseph R. Kraft, M.D., Chicago
David Greeley, M.D., Chicago
Norman Frank, M.D., Clarendon Hills
Lawrence Breslow, M.D., Northbrook
Byron J. Francis, M.D., Springfield
Mark Lepper, M.D., Chicago
James P. Paulissen, M.D., Springfield *Staff*

Hearing Advisory Committee

Phil B. Shattuck, Springfield
Miss Hazel Bothwell, Springfield
Kenneth Mangan, Jacksonville
Robert K. Simpson, Springfield
Raul Rittmanic, Dixon
H. L. McCarthy, Springfield
Ralph Naunton, M.D., Chicago
Noel Matkin, Evanston
John B. Hall, M.D., Chicago
Katherine Bumpus, East St. Louis.

Tuberculosis Advisory Committee

Ben Kiningham, Springfield
E. A. Piszczek, M.D., Chicago
John Egdorf, Hinsdale
Eric Peterson, M.D., Coal Valley
Mrs. Esther Smith, Chicago
W. D. Tuttle, M.D., Harrisburg
Virgil Smith, Metropolis

Sickle Cell Committee

Billie W. Adams, M.D., Chicago, *Chairman*
Julian Berman, M.D., Chicago
Rowine Brown, M.D., Chicago
Leon Finney, Chicago
Charles Hurst, Chicago
Nancy Jefferson, Chicago
Rev. Roy Neal, Chicago
Rev. Edward Reddick, Chicago
Joseph Semper, Chicago
Helen Sutton, Chicago
Florence Winfield, Chicago
James K. Polk, Peoria

Recreational Area Advisory Council

William G. Crumrin, Martinsville
Alvin Henninger, Garden Prairie
Charles Burrell, Antioch
Robert Stroyeck, Mt. Zion
Robert F. Sullivan, Springfield
Jerry Van Meter, Springfield
Frank Goetschel, New Lenox (ad hoc)
Tom Mracek, Springfield (ad hoc)

NON STATUTORY BOARDS

(Allied with Public Health Operations)

Committee for Revision of the Rules and Regulations for the Control of Communicable Diseases

Byron J. Francis, M.D., Springfield, *Chairman*
John B. Hall, M.D., Chicago
Mark Lepper, M.D., Chicago
Charles W. Elder, D.D.S., Johnston City
Richard A. Morrissey, Chicago
James P. Paulissen, M.D., Springfield
Harry Harding, M.D., Evanston
Olga Brolnitsky, M.D., Chicago

Advisory Committee for Heritable Metabolic Diseases

Herbert Grossman, M.D., Chicago
John B. Hall, M.D., Chicago
Herbert F. Philipsborn, Jr., Glencoe
Julian Berman, M.D., Chicago
Richard A. Morrissey, Chicago
Daniel F. Pachman, M.D., Chicago
Margaret O'Flynn, M.D., Chicago
Edward F. Lis, M.D., Springfield
Ira Rosenthal, M.D., Chicago

Grade A Milk Advisory Board

Franklin D. Yoder, M.D., Springfield, *Chairman*
George Baker, Moline
Dr. Willard J. Corbett, Rockford
Norman Eisenstein, Chicago
Clyde Fruit, Edwardsville
Fletcher Gourley, Springfield
Vernon Janes, Champaign
William B. Hanley, Chicago
Paul Scherschel, Chicago
Raymond Weinheimer, Highland
Howard K. Wells, Chicago
Michael Phillips, Bloomington

Technical Advisory Committee on Lasers

Isaac D. Abella, Ph.D., Chicago
Herman Cember, Ph.D., Evanston
Charles L. Cheever, Argonne
Nick Holonyak, Jr., Ph.D., Urbana
Clifford E. Mensing, Maywood
Frank W. Newell, M.D., Chicago

Illinois Committee for Medical Residencies in Public Health

Charles F. Sutton, M.D., Springfield, *Chairman*
John B. Hall, M.D., Chicago
Charles A. Lang, M.D., Wheaton

Mark H. Lepper, M.D., Chicago
James P. Paulissen, M.D., Springfield
Edward A. Piszczek, M.D., Forest Park
Eugene L. Wittenborn, M.P.H., Springfield
Vlado A. Getting, M.D., Ann Arbor, Mich.

Advisory Committee on Prevention of Accidental Poisoning in Children

Byron J. Francis, M.D., Springfield, *Chairman*
Joseph R. Christian, M.D., Chicago
W. L. Crawford, M.D., Rockford
J. Keller Mack, M.D., Springfield
Paul Pierce, M.D., Alton
John B. Stull, M.D., Olney
Walter M. Whitaker, M.D., Quincy

Advisory Committee on Pediatric Lead Poisoning

Fred Z. White, M.D., Chillicothe, *Chairman*
A. J. Kiessel, M.D., Decatur, *Vice-Chairman*
Ira M. Rosenthal, M.D., Chicago
Guy A. Pandola, M.D., Joliet
Eleanor Berman, Ph.D., Chicago
Henrietta K. Sachs, M.D., Glencoe
Ronald B. Mack, M.D., Berwyn
Rownie Hayes-Brown, M.D., Chicago
Richard A. Morrissey, Chicago
Verdun Randolph, Springfield
Philip R. Fine, Ph.D., Springfield

Advisory Committee to the Program for Care of Premature and High Risk Infants

Joseph V. Brazie, M.D., Chicago
Michael McKeown, M.D., Chicago
Robert R. Hartman, M.D., Jacksonville
Peter McFarland, M.D., Alton
Joseph Christian, M.D., Chicago
Robert Misenheimer, M.D., Chicago
Gerald F. Staub, M.D., Rockford
W. Robert Elghammer, M.D., Danville
William R. Hamilton, M.D., Carbondale
John Boehm, M.D., Evanston
William Albers, M.D., Peoria
Jess Diamond, M.D., Springfield
James P. Paulissen, M.D., Springfield
Paul Granoff, M.D., Aurora

Youth Camp Advisory Council

Gordon Kaplan, Chicago
Elizabeth Weir, Hudson
Marvin Erdal, Lake Villa
Mary E. Couzens, Freeport
John Pearson, Round Lake
Maury Swiryn, Mundelein
Virginia Breckenridge, Peoria
Jay Heim, Springfield
Mabel West, Herrin

Advisory Committee for Critically Injured Patient

Executive Committee

David R. Boyd, M.D.C.M., *Chairman*
Chief, Division of Emergency Medical Services and Highway Safety, Illinois Department of Public Health
Assitant Professor of Surgery
Abraham Lincoln School of Medicine
Trauma Unit, Cook County Hospital
Bruce A. Flashner, M.D., *Program Coordinator*
Deputy Director, Illinois Department of Public Health

W. Eugene Cowsert, *Chairman*
Subcommittee on Transportation and Communications
David M. Kinzer, *Chairman*
Subcommittee on Regionalization
C. O. Metzmaker, M.D., *Chairman*
Subcommittee on Training and Education
Lloyd M. Nyhus, M.D., *Chairman*
Subcommittee on Trauma Management
Norman J. Rose, M.D., *Chairman*
Subcommittee on Epidemiology

DEPARTMENT OF REGISTRATION AND EDUCATION

William H. Robinson, *Director*
Allen M. Andreasen, *Assistant Director*
Edward Price, *Coordinator,*
Division of Professional Supervision

The department is primarily concerned with the registration, licensing and enforcement of 32 laws governing the different professions, trades and occupations, including the Medical Practice Act. Enforcement of the Medical Practice Act is in the Division of Professional Supervision headed by a coordinator. Registration and licensing is under the jurisdiction of the Division of Registration.

The Medical Examining Committee appointed by the director of the department operates within the framework of the act and is charged with the responsibility of giving examinations for licensure, hearing complaints for revocation and suspension of licenses and promulgating rules and regulations for the administration of the act.

Medical Examining Committee

Kenneth H. Schnepp, M.D., *Chairman*
Eugene Hoffmann, D.C.
William G. McCarthy, M.D.
Dale E. Richardson, D.O.
S. David Ross, M.D.
Nat E. Smith, M.D.
Warren D. Tuttle, M.D.

Medical Practice Act

Licensing and Enforcement Procedures

Illinois statutes provide for licensing of physicians to practice medicine "(1) in all of its branches, and (2) licensing of those persons to treat human ailments without the use of drugs or medicine and without operative surgery."

The Medical Practice Act states, "no person shall practice medicine, or any of its branches, or midwifery, or any system or method of treating

human ailments without the use of drugs or medicines and without operative surgery, without a valid existing license so to do." Applicant for license must pass an examination of his qualifications which must be satisfactory to the Department of Registration and Education.

This act does not prohibit the practice of medicine by a person who is licensed to practice medicine in all of its branches in any other state of the United States or the District of Columbia who has applied in writing to the Department, in form and substance satisfactory to the Department, for a license to practice medicine in all of its branches and has complied with all of the provisions of Section 13, except the passing of an examination which may be given under Section 13, until:

(a) the expiration of 6 months after the filing of such written application, or

(b) the decision of the Department that the applicant has failed to pass an examination within 6 months or failed without an approved excuse to take an examination conducted within 6 months by the Department, or

(c) the withdrawal of the application. (Added by Act approved July 26, 1971)

Any person licensed under this Act who dispenses any drug or medicine shall affix to the box, bottle, vessel or package containing the same a label indicating (a) the date on which such drug or medicine is dispensed; (b) the last name of the person dispensing such drug or medicine; (c) the directions for use thereof; and (d) the proprietary name or names or, if there is none, the established name or names of the drug or medicine, the dosage and quantity, unless the person dispensing the drug or medicine determines that the health of the person to whom the drug or medicine is dispensed requires that such information be omitted. This Section shall not apply to drugs or medicines in a package which bears a label of the manufacturer containing information describing its contents which is in compliance with requirements of the Federal Food, Drug and Cosmetic Act and the Illinois Food, Drug and Cosmetic Act and which is dispensed without consideration by a practitioner licensed under this Act. "Drug" and "medicine" have the meaning ascribed to them in the "Pharmacy Practice Act," approved July 11, 1955, as now or hereafter amended. (Added by Act approved September 24, 1971)

Minimum standards of professional education. Except as provided in Section 9a of this Act, the minimum standards of professional education to be enforced by the department in conducting examinations and issuing licenses shall be as follows:

1. *Practice of Medicine.* For the practice of medicine in all of its branches:

(a) For an applicant who is a graduate of a medical college before the passage of this Act, that such medical college at the time of his graduation required as a prerequisite to graduation a 4 years' course of instruction of not less than 9 months each, in such medical college, or its equivalent, the time elapsing between the beginning of the first year and the ending of the fourth year having been not less than 40 months, and which was reputable and in good standing in the judgment of the department; and prior to taking such examination said applicant must present proof that he has completed a 4 years' course of instruction in a high school or its equivalent as determined by an examination conducted by the department.

(b) For an applicant who is a graduate of a medical college after the passage of this Act, that such medical college at the time of his graduation required as a prerequisite to admission thereto 2 years' course of instruction in a college of liberal arts, or its equivalent, or in such medical college, and a course of instruction in a medical college in the treatment of human ailments, which course shall have been not less than 132 weeks in duration and shall have been completed within a period of not less than 35 months, and in addition thereto, a course of clinical training of not less than 12 months in a hospital, such college of liberal arts, medical college and hospital having been reputable and in good standing in the judgment of the department.

The time requirement of not less than 132 weeks within a period of 35 months, set forth above, may be reduced by the department upon recommendation of the Dean of the medical school in the case of programs involving students with advanced standing. (added by Act approved July 26, 1971).

2. *Treating human ailments without drugs or medicines and without operative surgery.* For the practice of any system or method of treating human ailments without the use of drugs or medicines and without operative surgery:

(a) For an applicant who was a resident student and who is a graduate before July 1, 1926, of a professional school, college or institution which taught the system or method of treating human ailments, which he specifically designated in his application as the one he would undertake to practice, that such school, college or institution at the time of his graduation required as a prerequisite to graduation a 3 years' course of instruction of not less than 6 months each, the time elapsing between the beginning of the first year and the ending of the third year having been not less than 22 months, and which are reputable and in good standing in the judgment of the department and prior to taking the examination the applicant must present proof that he has completed a 4 years' course of instruction in high school, or its equivalent, as determined by an examination conducted by the department.

(b) For an applicant who was a resident student and who is a graduate after July 1, 1926, of a professional school, college or institution which taught the system or method of treating human ailments which he specifically designated in his application as the one which he would undertake to practice, that such school, college or institution at the time of his graduation required as a prerequisite to admission thereto a 4 years' course of instruction in a high school, and as a prerequisite to graduation therefrom a course of instruction in the treatment of human ailments, of not less than 132 weeks in duration and shall have been completed within a period of not less than 35 months except that as to students matriculating or entering upon a course of study of any system or method of treating human ailments without the use of drugs or medicines and without operative surgery during the years 1940, 1941, 1942, 1943, 1944, 1945, 1946

and 1947, the said elapsed time shall be not less than 32 months, such high school and such school, college, institution having been reputable and in good standing in the judgment of the department.

(c) For an applicant who is a matriculant in a chiropractic college after September 1, 1969, that such applicant shall be required as a prerequisite for admission to examine for licensure, to complete a 2 years' course of instruction in a liberal arts college or its equivalent, and a course of instruction in a chiropractic college in the treatment of human ailments, such course as a prerequisite to graduation therefrom having been not less than 132 weeks in duration and shall have been completed within a period of not less than 35 months, such college of liberal arts and chiropractic college having been reputable and in good standing in the judgment of the Department.

3. *Midwifery*. For the practice of midwifery: That he be a graduate of a college of midwifery which requires as a prerequisite to admission thereto, a one year's course of instruction in a high school or its equivalent, and required as a prerequisite to graduation, a one year's course in such college of midwifery, the time actually spent under instruction in such college of midwifery to have been not less than 12 months; such high school or equivalent school, and such college of midwifery having been in good standing in the judgment of the department.

Without prejudice to licenses heretofore issued under this section, no further licenses shall be issued under this section after the effective date of this amendment. As amended by act approved Aug. 2, 1965.

All examinations provided for by the Medical Practice Act shall be conducted by the Department of R&E. Examinations of applicants who seek to practice medicine in all of its branches shall embrace the subjects of which knowledge is generally required of candidates for the degree of Doctor of Medicine by reputable medical colleges in the U.S., and shall be such in the judgment of the Department of R&E that as will determine the qualifications of applicants to practice medicine in all of its branches.

Every license issued under the Act expires on July 1 of each even-numbered year. Every licensee under the Act may, biennially during the month of June of each even-numbered year, renew his license upon paying to the Department a renewal fee of $10.

Revocation and Suspension of License or Certificate

The Department may revoke, or suspend, place on probationary status, or take any other disciplinary action as the Department may deem proper with regard to the license, certificate or state hospital permit of any person issued under this Act or under any other Act in this State to practice medicine, to practice the treatment of human ailments in any manner or to practice midwifery, or may refuse to grant a license, certificate or state hospital permit under this Act or may grant a license, certificate or state hospital permit on a probationary status subject to the limitations of the probation, and may cause any license or certificate which has been the subject of formal disciplinary procedure to be marked accordingly on the records of any county clerk upon the following grounds:

"1. Conviction of procuring or attempting or aiding to procure such an abortion as was made unlawful at the time under the Criminal Code of this State;

2. Conviction in this or another state of any crime which is a felony under the laws of this state or conviction of a felony in a federal court, if the Department determines, that after investigation, that such person has not been sufficiently rehabilitated to warrant the public trust; (as amended by Act approved July 23, 1971).

3. Gross malpractice resulting in permanent injury or death of a patient;

4. Engaging in dishonorable, unethical or unprofessional conduct of a character likely to deceive, defraud, or harm the public;

5. Obtaining a fee, either directly or indirectly, either in money or in the form of anything else of value or in the form of financial profit as personal compensation, or as compensation, charge, profit or gain for an employer or for any other person or persons, on the fraudulent representation that a manifestly incurable condition of sickness, disease or injury of any person can be permanently cured;

6. Habitual intemperance in the use of ardent spirits, narcotics, or stimulants to such an extent as to incapacitate for performance of professional duties;

7. Holding one's self out to treat human ailments under any name other than his own, or the personation of any other physician;

8. Employment of fraud, deception or any unlawful means in applying for or securing a license, certificate, or state hospital permit to practice the treatment of human ailments in any manner, to practice midwifery, or in passing an examination therefor, or willful and fraudulent violation of the rules and regulations of the department governing examinations;

9. Holding one's self out to treat human ailments by making false statements, or by specifically designating any disease, or group of diseases and making false claims of one's skill or the efficacy or value of one's medicine, treatment or remedy therefor;

10. Professional connection or association with, or lending one's name to, another for the illegal practice by another of the treatment

of human ailments as a business, or professional connection or association with any person, firm, or corporation holding himself, themselves, or itself out in any manner contrary to this Act;

11. Revocation or suspension of a medical license in a sister state;

12. A violation of any provision of this Act or of the rules and regulations formulated for the administration of this Act;

13. Except as otherwise provided in Section 16.01, advertising or soliciting by himself or through another, by means of hand bills, posters, circulars, stereopticon slides, motion pictures, radio, newspapers or in any other manner for professional business."

14. A finding by the Committee that the registrant after having his license placed on probationary status violated the terms of the probation.

 All proceedings to suspend, revoke, place on probationary status, or take any other disciplinary action as the Department may deem proper with regard to a license, certificate or state hospital permit on any of the foregoing grounds, except the ground numbered 8 (fraudulent grounds) must be commenced within 3 years next after the conviction or commission of any of the acts described therein, except as otherwise provided by law; but the time during which the holder of the license, certificate or state hospital permit was without the State of Illinois shall not be included within the 3 years.

 The entry of a decree by any circuit court establishing that any person holding a license, certificate or state hospital permit under this Act is a person in need of mental treatment operates as a suspension of that license, certificate or state hospital permit. That person may resume his practice only upon a finding by the Committee of Physicians that he has been determined to be recovered from mental illness by the court and upon the Committee's recommendation that he be permitted to resume his practice. (added by Act approved July 26, 1971).

15. Directly or indirectly giving to or receiving from any physician, person, firm or corporation any fee, commission, rebate or other form of compensation for any professional services not actually and personally rendered. Nothing contained in this subsection prohibits persons holding valid and current licenses under this Act from practicing medicine in partnership under a partnership agreement or in a corporation authorized by "The Medical Corporation Act" as now or hereafter amended or as an association authorized by "The Professional Association Act" as now or hereafter amended, or under "The Professional Corporation Act" as now or hereafter amended, from pooling, sharing, dividing or apportioning the fees and monies received by them or by the partnership, corporation or association in accordance with the partnership agreement or the policies of the Board of Directors of the corporation or association. Nothing contained in this subsection shall abrogate the right of two or more persons holding valid and current licenses under this Act to receive adequate compensation for concurrently rendering professional services to a patient and divided a fee: provided, the patient has full knowledge of the division, and provided that the division is made in proportion to the services performed and responsibility assumed by each. (added by Act approved July 31, 1971).

Section 16.01. Any person licensed under this Act may list his name, title, office hours, address, telephone number and any specialty in professional and telephone directories; may announce by way of a professional card not larger than 3½ inches by 2 inches, only his name, title, degree, office location, office hours, phone number, residence address and phone number and any specialty; may list his name, title, address and telephone number and any specialty in public print limited to the number of lines necessary to state that information; may announce his change of place of business; absence from, or return to business in the same manner; or may issue appointment cards to his patients, when information thereon is limited to the time and place of appointment and that information permitted on the professional card. Listings in public print, in professional and telephone directories, or announcements of change of place of business, absence from, or return to business, may not be made in bold faced type.

Rules and Regulations Adopted for the Administration of the Illinois Medical Practice Act, Effective March 18, 1955

RULE 1—ACCREDITED COLLEGES OF MEDICINE AND SURGERY

Medical colleges having rules and curricula commensurate with and equivalent to the rules and curricula of the College of Medicine of the University of Illinois, will be considered for accreditation by the Department of Registration and Education.

RULE II—ACCREDITED COLLEGES TEACHING SYSTEMS OF TREATING HUMAN AILMENTS WITHOUT THE USE OF DRUGS OR MEDICINE AND WITHOUT OPERATIVE SURGERY.

A professional college or institution teaching a system of treating human ailments without the use of drugs or medicine and without operative surgery shall be deemed reputable and in good standing in the judgment of the Department upon submission of proof of the following requirements:

(a) That a Dean or other Executive Officer, employed on a full-time basis supervises the students and curriculum.

(b) That the faculty is comprised of graduates in their specialty from recognized professional colleges or institutions.

(c) That the faculty is organized and each department has a director, professors, associate professors and assistant professors, each responsible to his superior for his instruction in the particular subject he teaches.

(d) That, annually, a catalogue or brochure is published setting forth the requisites for admission to the college, tuition rates, courses offered, dates of sessions, schedule of classes, requirements for graduation, a roster of the undergraduate students and a roster of the last graduating class. The catalogue or brochure shall contain a list of the departments of the school, the titles of the personnel and a brief summary of each person's qualifications. The curriculum shall include, but not be limited to, four academic years' instruction in the following subjects:

(1) Anatomy
 (a) Embryology; (b) Histology; (c) Neuroanatomy
(2) Physiology and Chemistry
(3) Pathology and Bacteriology
(4) Diagnosis
 (a) Physical; (b) Differential; (c) Laboratory

(e) That suitable buildings provided with laboratories equipped for instruction in anatomy, chemistry, physiology, bacteriology and other areas of learning necessary to the due course of study prescribed by these rules; and that a laboratory equipped with supplies, models, manikins, charts, stereopticon, roentgen-ray and other special apparatus used in teaching the system to treat human ailments without the use of medicine and operative surgery, be provided.

(f) That a working library, easily accessible to students, is maintained from at least 9 a.m. to 5 p.m., with a librarian in constant attendance. The library shall contain a standard medical dictionary, the modern text and reference books, and the files of leading periodicals dealing with the particular system of treating human ailments without the use of medicine and operative surgery.

(g) That the college or institution requires all students to furnish, before matriculation, satisfactory proof of the preliminary education required by the Medical Practice Act.

(h) That full and complete records are kept showing the credentials for admission, attendance, grades and financial accounts of each student.

(i) That admission of transfer students will be limited to honorably dismissed students from another approved college or institution teaching the same system. The transcript of record obtained directly from the transferring school shall be kept on file. It shall be the duty of a college or institution to furnish such a transcript for the benefit of each student subject to honorable dismissal. No credit shall be given a transferred student for final or "senior year" work or for any courses taken by correspondence.

(j) That students shall start class attendance within one week of the start of each session. That credit for completion of a course will not be granted a student who failed to attend 80 per cent of the complete session of the course.

RULE III—HOSPITALS APPROVED FOR INTERNSHIP.

1. A hospital shall, in the judgment of the Department be deemed reputable and in good standing for training interns and intern services when it meets the following standards:

(a) General hospital of 150 beds' capacity, with an average of at least 60 patients daily, with rotating service.

(b) Shall contain at least the departments of internal medicine, surgery, obstetrics and pediatrics; and an organized departmentalized staff, holding meetings monthly for case reviews and study.

(c) Laboratory employing a full-time qualified technician and at least a part-time qualified pathologist, visiting the laboratory at least two days per week.

(d) Radiological department employing a qualified X-ray technician and at least a part-time qualified roentgenologist, visiting the department at least two days per week.

(e) Maintenance of an up-to-date medical library located in a suitable study room available to interns.

(f) Such hospital shall provide and furnish the Department with the names of staff members of the various departments of the hospital.

(g) The hospital, upon the completion of a course of training therein of not less than twelve months, shall issue its certificate therefor to any such intern or at the request of the Department, such certificate shall include therein, by date, the commencement and the conclusion thereof.

2. An approved internship shall consist of twelve months rotating service in medicine, surgery, obstetrics and pediatrics, with an election in medical specialties.

In the event an applicant has received training in excess of the twelve months' period specified by the Medical Practice Act, and if this be in an institution approved by the Department as adequate for specialty training; and if the applicant has received certification by a recognized Medical Specialty Board, and has had two or more years' specialty practice or Military Service; such training and practice may be accepted as the equivalent of a rotating internship.

Any applicant who shall have completed twelve months of clinical training in a hospital, as required by Section 5-1(b) of the Medical Practice

Act, and who has been accepted for further training in a specialty or general practice residency program by a hospital or institution approved by the Department for that purpose, shall be deemed to have complied with the requirements of this rule and of the Medical Practice Act in this regard.

Rule IV—Application for Examination

An applicant for examination for licensure to practice medicine in all of its branches, or any system of treating human ailments without the use of drugs or medicine and without operative surgery, must make application on forms furnished by the Department at least fifteen days prior to the examination and present, in addition:

(a) Recommendations from two (2) physicians duly licensed to practice in some state in the United States.

(b) A recent photograph, passport size, signed by applicant and two persons licensed to practice the system of treatment of human ailments for which the applicant is seeking a license. A duplicate photograph must be presented with the card of admission at the examination.

(c) The original diploma of graduation from the professional college in which the applicant completed his course of training, or, in lieu of presenting the diploma with the application, the applicant may present it at the examination.

(d) A certified copy of secondary school and professional school studies to be mailed direct to the Department by the schools attended or by the professional schools where the applicant completed the required course of study.

(e) Proof of completion of a rotating internship of twelve months in an approved hospital for applicants seeking admission to examination for license to practice medicine in all of its branches; and, in the case of graduates of medical colleges in countries other than the United States and Canada, who apply for examination after January 1, 1953, proof of rotating internships of one year in approved hospitals in the United States.

A candidate under Section 5, paragraph 1-b, or Section 13, may apply for the examination or clinical test and take the examination given immediately prior to completion of his internship provided he furnishes a statement from the hospital authorities stating his internship has been satisfactory to date. The results of the examination will be withheld and no license will be issued until the Department receives proof of satisfactory completion of the required internship in an approved hospital training program.

(f) Applicants who completed their medical courses in the extramural colleges of Ireland and Scotland shall not be eligible for admission to examinations for licensure under the Illinois Medical Practice Act.

(g) Graduates of European medical colleges or universities after January 1, 1943, with the exception of certain approved colleges in the British Isles, Denmark, Holland, Norway, Sweden and Switzerland, be not accepted for admission to examinations for licensure under the Illinois Medical Practice Act.

Graduates of such European medical colleges after January 1, 1943 may be considered for admission to Illinois examinations provided they present diplomas of graduation from approved medical colleges in the United States after attendance in such colleges for at least one year; and in addition, have served rotating interships of one year in approved hospitals in the United States.

(h) An applicant who presented a diploma of graduation from an approved school will not be accepted, if he was accorded advanced standing in such school based upon his prior education in an unapproved school.

Rule V—Examinations

1. Examinations for licensure to practice medicine in all of its branches shall be conducted in the English language and shall be in the following theoretical and practical areas of medicine:

Theoretical

Chemistry, Physiology, Anatomy, Pharmacology, Pathology, Bacteriology, Medicine, Public Health & Preventive Medicine, Obstetrics & Gynecology, Surgery, Pediatrics, Psychiatry

Clinical

General Practice of Medicine

2. Examinations for licensure to practice the treatment of human ailments without the use of drugs or medicine and without operative surgery shall be conducted in the English language and shall be in the following theoretical and practical subjects:

Theoretical

Chemistry & Physiology, Anatomy & Histology, Pathology & Bacteriology, Diagnosis, Hygiene & Medical Jurisprudence, Eye, Ear, Nose, & Throat, Dermatology, Pediatrics & Neurology, System of Practice, Obstetrics (of graduates of approved osteopathic colleges)

Practical

System of Practice

3. To be successful, applicants must receive general averages of 75% with no grade below 60 in the written examination, and a general average of 75% in the clinical or practical test.

Applicants applying for registration under Sections 12 and 12a of the Medical Practice Act shall be required to make general averages of 75% in the three subjects required for license to practice medicine and surgery in Illinois.

4. In case of failure in the first and second examinations applicants will be allowed credit on the following examination for all grades of 75 or more; but in case of failure in the third examination they must retake all written subjects at each subsequent examination. It is not required that the clinical or practical part of the examination be repeated after a passing grade of 75% has been received in that part of the examination.

5. Applicants who take the regular written examination conducted by the Department for licenses as Physicians and Surgeons shall be excused from taking the clinical test.

6. An applicant for registration as Physician and Surgeon who has been unsuccessful in five examinations will be deemed to be eligible for further examination upon receipt of proof that he has completed one year of residency training in an approved hospital training program in the United States received subsequent to the applicant's fifth failure.

7. An applicant who has been unsuccessful in five examinations for registration as a drugless practitioner will be eligible for reexamination upon receipt of proof that he has completed a course of study of 960 hours in a school which is accredited under the Medical Practice Act. This course must be received subsequent to the applicant's fifth failure.

8. An applicant who furnished proof of a course of study of 240 hours in a school of chiropractic recognized by the Department in order to be eligible for further examination under Section 9a of the Medical Practice Act will be considered as a new applicant and his grades of 75 per cent or more will be carried over to the second and third examinations.

Rule VI—Reciprocity

1. Each applicant for registration through reciprocity, either for the practice of medicine in all of its branches or for the treatment of human ailments without the use of drugs or medicine and without operative surgery, filed on forms provided by the Department, will be considered on its individual merits, provided the state or territory of original licensure grants a like privilege to persons licensed in Illinois.

2. If the application is not endorsed by officers of a state or county society it must be endorsed by two (2) physicians duly licensed to practice in some state in the United States.

3. Applicants for licensure through reciprocity or upon the basis of having passed the National Board Examination prior to January 1, 1964, must pass the clinical test conducted by this Department. Applicants upon the basis of the National Board Examination who completed Part III after January 1, 1964, are required to report for an interview with the Medical Examining Committee. The clinical test shall be such in the judgment of the Committee as will determine the qualifications of the applicant to practice medicine in all of its branches, taking into consideration the quality of medical education and clinical training or practical experience which the applicant has had, special honors or awards, publications in recognized and reputable journals, authorship of textbooks in medicine, and any other circumstance or attribute that the Committee accepts as evidence of an outstanding and proven ability in any branch of the field of medicine.

4. Graduates of Chiropractic colleges whose applications for registration in Illinois by reciprocity are approved, shall be required to pass a written examination in theory in addition to a practical test before the chiropractic examiner.

Rule VII—Licensure

1. An examinate who successfully completes his medical examination must secure his certificate of licensure within one year from the date of his examination.

2. The Department will not issue a duplicate certificate of registration to practice medicine in all of its branches, or to treat human ailments without the use of drugs or medicine and without operative surgery, unless proof satisfactory to the Department and the Committee is presented that the original certificate was destroyed; or in case of change of name when the original certificate is returned for cancellation, together with satisfactory legal proof of such change of name.

3. A license to practice medicine in Illinois shall be a requisite for a residency in an Illinois hospital.

Rule VIII—Temporary Certificates of Registration

1. Any person not licensed to practice medicine in all of its branches in the State of Illinois who wishes to pursue a program of graduate or specialty or residency training in this State, must be the holder of a Temporary Certificate of Registration issued by the Department under the provisions of Section 11a of the Medical Practice Act of Illinois and in accordance with the provisions of the within Rules.

2. Application for a Temporary Certificate must be made on blank forms prepared and furnished by the Department. It must be submitted to the Department together with evidence satisfactory to the Department that applicant meets the requirements of Section 11a of the Illinois Medical Practice Act and that if his application is approved he will be accepted or appointed for the residency training in the hospital designated in such application.

3. A Temporary Certificate of Registration will be issued on behalf of an otherwise qualified appli-

cant only for residency or specialty training in a hospital situated in this State which is approved by the Department for the purpose of such training. An approved hospital is one which in the judgment of the Department is qualified to offer such training, and which shall comply with the within Rules.

4. Written notice of the Department's final action on every application for a Temporary Certificate of Registration shall be given to the applicant and the hospital designated therein; when such application is approved the Temporary Certificate of Registration shall be delivered or mailed to the hospital designated therein and shall be kept in the care and custody of such hospital. The applicant shall not commence such specialty or residency training before he or the hospital receives written notification of approval of his application.

5. A Temporary Certificate of Registration shall not be valid for longer than one year after issuance thereof and may be renewed from time to time, in the discretion of the Department, for a period of not more than one year each time. Application for renewal must be made on forms prepared and furnished by the Department and the Temporary Certificate of Registration sought to be renewed must be submitted therewith to the Department.

6. When any person in whose behalf a Temporary Certificate of Registration has been issued shall be discharged or shall terminate his specialty or residency training in the hospital designated therein, such hospital shall immediately deliver or mail by registered mail to the Department his Temporary Certificate of Registration and written notice of the reason for return of same.

7. A Temporary Certificate of Registration is not transferable without prior notice to and approval by the Department. If the holder of a Temporary Certificate of Registration wishes to change to another training program in the approved hospital designated therein, or he wishes to enter a training program in another approved hospital, he must make application on Forms furnished by the Department. His current Temporary Certificate of Registration must accompany such application and he cannot thereafter continue in the training program designated on such current Certificate, and he may not commence such other training program until a Temporary Certificate of Registration has been issued therefor.

8. Not more than one Temporary Certificate of Registration shall be issued to any person for the same period of time. A person on whose behalf a Temporary Certificate of Registration has been issued is limited in the practice of medicine to the performing of such acts as may be prescribed by and incidental to his program of residency training in the hospital designated in his Temporary Certificate of Registration, and he cannot otherwise engage in the practice of medicine in the State of Illinois.

9. Whenever, under the within Rules, a hospital is required to deliver or return a Temporary Certificate of Registration to the Department, in case, because of the loss or destruction of such Certificate, or for any other reason, such hospital shall be unable immediately so to deliver or mail such Certificate, such hospital shall immediately mail or deliver to the Department a written explanation in detail of such inability.

10. The holder of a Temporary Certificate of Registration is not barred thereby from becoming eligible for admission to the Department examination for a license to practice medicine in Illinois if he otherwise meets the requirements for admission to such examination and if such person should fail to pass such examination such failure shall not bar him from completing his training program.

Rule IX—Limited Licenses to Practice in State Hospitals

1. Each application made on forms provided by the Department will be considered on its own merits.

2. The State Hospital at which the applicant will practice under the supervision of a medical officer, shall signify to the Department that the hospital will appoint the applicant in the event he receives a Limited License.

3. Any applicant for a Limited License who has failed in more than three examinations for licensure under the Illinois Medical Practice Act shall not be eligible for a Limited License.

4. State hospital permits of physicians not otherwise licensed to practice may be renewed only twice after July 1, 1973, for one year periods each, with all original permits and renewals to expire on July 1 after issuance. After July 1, 1974, all permit holders seeking renewal will be required to pass new examination given by Department of Registration and Education, or an equivalent examination.

ECFMG REQUIREMENTS

The Education Council for Foreign Medical Graduates (ECFMG) commenced operations in October, 1957. Sponsors of this agency are the American Hospital Association, American Medical Association, Association of American Medical Colleges, and Federation of State Medical Boards of the United States. ECFMG gives two examinations a year to foreign medical graduates. The examinations test the graduate's general knowledge of medicine and command of English.

Persons successfully passing this examination are granted an ECFMG certificate. This certificate in the State of Illinois is **not a substitute** for nor is it the equivalent of licensure to practice medicine. It simply indicates that the holder's command of English has been tested and found adequate for assuming an internship in an American hospital. The holder of such a certificate may not practice medicine in any degree in a hospital in Illinois unless he is within one of the categories outlined above.

Offenses Listed

An unlicensed person who commits any of the following acts regardless of whether the same be committed within or without a hospital is guilty of practicing medicine without a license—a criminal offense:

1. Hold himself out to the public as being engaged in the diagnosis or treatment of ailments of human beings.
2. Suggest, recommend or prescribe any form of treatment for the palliation, relief or cure of any physical or mental ailment of a person with the intention of receiving therefor, either directly or indirectly, any fee, gift, or compensation whatsoever.
3. Diagnosticate or attempt to diagnosticate any ailment or supposed ailment of another.
4. Operate upon, profess to heal, prescribe for, or otherwise treat any ailment, or supposed ailment of another.
5. Maintain an office for examination or treatment of persons afflicted, or alleged or supposed to be afflicted, by any ailment.
6. Attach the title Doctor, Physician, Surgeon, M.D., or any other word or abbreviation to his name, indicative that he is engaged in the treatment of human ailments as a business.

(*Medical Practice Act.* [Chp. 91, Sec. 16i, Paragraph 24, *1967 Rev. Stat.*])

Manifestly, the enforcement of the Medical Practice Act with respect to the elimination of unlicensed persons practicing medicine in a hospital is dependent upon co-operation by responsible persons within the hospital. It should be noted that lack of co-operation or failure to meet responsibilities can in a proper case be translated into criminal liability and disciplinary action resulting in revocation or suspenson of a license to practice medicine as follows:

1. The unlicensed person practicing medicine is committing a criminal offense.
2. A hospital administrator who assigns an unlicensed person to duties which involve his practicing medicine may subject himself to the criminal offense of aiding and abetting such unlicensed person to illegally practice medicine, and the same may be true of a hospital chief of staff or department head if in the nature of his duties he is directly responsible for assigning such duties to the unlicensed person.
3. A licensed doctor may have his license suspended or revoked if he has professional connection or association with another who is illegally practicing medicine. A chief of staff who knowingly allows such person to illegally practice medicine, or in a proper case, any member of the medical staff of a hospital may subject himself to disciplinary action against his license.
4. A licensed doctor may have his license suspended or revoked for unethical or unprofessional conduct of a character likely to deceive, defraud or harm the public.

 A member of the medical staff of a hospital may place himself within such conduct if he neglects, fails or refuses to fulfill his responsibilities while on emergency room call.

Other Examining Boards

Other examining boards operating under the jurisdiction of the Department of Registration and Education are:

Podiatry Examining Committee
Charles H. Delano, D.P.M., *Chairman*
Alva J. Harler, D.S.C.
Dr. Joseph M. Giannini

Dental Examining Committee
Hugh D. Burke, Sr., D.D.S.
Ralph H. Council, D.D.S.
Herbert Gustavson, D.D.S.
Sidney Neuwirth, D.D.S.
William T. Osmanski, D.D.S.
Richard Schmitz, D.D.S.

Committee of Nursing Examiners
Miss Patricia A. Wagner, Prof., *Chairman*
Mrs. Donna Hessler
Sr. Mary Frances Cooke
Mrs. Ina Ingwersen
Miss Lillian G. Oertel
Mrs. Harriet S. Olson
Miss Marion Lennan

Optometric Examining Committee
Jose E. Aponte, O.D., *Chairman*
Gene Ossello, O.D.
Robert W. Stoelzle, O.D.
Floyd Woods, O.D.
Henry R. Moore

Illinois State Board of Pharmacy
Mr. John Barlow
Mr. Louis Gdalman
Mr. Richard Hilden
Mr. Fred L. Janes
Dr. Daniel Nona
Mr. Philip Sacks
Mr. Irwin S. Thornton

Physical Therapy Examining Committee
Miss Vilma Evans, R.P.T., *Chairman*
Mr. Robert Babbs, Jr.
Mr. James Mason Gray
Mr. John J. Mustari
Arthur A. Rodriquez, M.D.

Psychologists Examining Committee
Helen Sunakjian, Ph.D.
Frank Kobler, Ph.D.
Roy Brener, Ph.D.
Wendell Dysinger, Ph.D.
Dorothy Jean Dettmar

DIVISION OF VOCATIONAL REHABILITATION

The Board of Vocational Education and Rehabilitation is a statutory body, established to administer, through two operating divisions, the state program of vocational and technical education pursuant to the Federal Vocational Education Act as amended, and the state program of vocational rehabilitation pursuant to the Federal Vocational Rehabilitation Act as amended.

Board of Vocational Education and Rehabilitation

Statutory Members

Dr. Michael J. Bakalis
Superintendent of Public Instruction
302 State Office Building, Springfield 62706

Gordon L. Ropp, Director
Department of Agriculture
Junior Livestock Bldg, State Fairgrounds,
Springfield 62706

William Robinson, Director
Department of Registration & Education
628 East Adams Street, Springfield 62706

Albert J. Glass, M.D., Director
Department of Mental Health
401 State Office Building, Springfield 62706

Barney J. Grabiec, Director
Department of Labor
103 State Office Building, Springfield 62706

Franklin D. Yoder, M.D., M.P.H., Director
Department of Public Health
535 West Jefferson, Springfield 62706

Mrs. Jimi Lawrence, Director
Department of Children & Family Services
524 South Second-Lincoln Towers, Springfield 62706

Lay Members

James W. Cook, Chairman of the Board
1200 Whitebridge Hill, Winnetka 60093

Mr. Richard Ehrman, Manager Relations
General Electric Company
Route 66 and Towanda Avenue, Bloomington 61701

Mr. Robert Friedlander, Consultant
135 South LaSalle Street, Chicago 60603

Mr. Stanley Hutchison, President
Washington National Corporation, Evanston 60201

Mr. Stuart Mamer, Attorney
Thomas, Mulliken & Mamer
First National Bank Building, Champaign 61820

Mr. Warner Saunders, Executive Director
Better Boys Foundation
1512 South Pulaski Road, Chicago 60623

ILLINOIS REGIONAL MEDICAL PROGRAM
REGIONAL ADVISORY GROUP

The Illinois Regional Medical Program, which began in 1967, is a federally funded but autonomous organization charged with improving the health care of the citizens of the state of Illinois. The program objectives are a single standard of high quality health care, provided with maximum effectiveness at minimal cost, and accessible to all. IRMP supports and engages in activities aimed at: 1) improving the health care delivery system 2) increasing the availability and capability of health care personnel and 3) controlling major diseases. The Regional Advisory Group, the policy-making body of the IRMP, must approve all project applications for funding. The RAG is composed of representatives from the medical profession, allied health professions, hospital administration, planning agencies, voluntary and official health groups, medical schools and teaching hospitals in the state, as well as members of the general public familiar with the financing of, and the need for, health care.

Regional Advisory Group

Dexter Nelson, M.D., Princeton, *Chairman*
Donald P. Colleton, Chicago, *Vice-Chairman*
Leonidas H. Berry, M.D., Chicago
Daniel K. Bloomfield, M.D., Urbana
Edward F. Brabec, Chicago
Josephine A. Brandt, R.N., Moline
Andrew Brislen, M.D., Chicago
Donald J. Caseley, M.D., Chicago
Jacob Cates, Belvidere
Louis deBoer, Chicago
Vilma Evans, R.P.T., Danville
Cecelia Fennessy, R.N., Chicago
Merle H. Glick, Peoria
Stanley Goldstein, M.D., Decatur
John Grede, Ph.D., Chicago
Arthur L. Grist, Edwardsville
William J. Grove, M.D., Chicago
Emanuel Hallowitz, Chicago
George K. Hendrix, Springfield
Leon O. Jacobson, M.D., Chicago
Irwin Jarett, Ph.D., Springfield
Allen Kelly, Eldorado
Richard H. Kessler, M.D., Chicago
Robert A. Kistner, D.O., M.D., Chicago
Marion Lamet, Warsaw
August P. Lemberger, Ph.D., Chicago
Mark H. Lepper, M.D., Chicago
LeRoy P. Levitt, M.D., Chicago
Henry J. Luckhardt, O.D., Westmount
Charles Marshall, Chicago
W. Henderson May, Springfield
Harold W. Maysent, Rockford
E. Duke McNeil, Chicago
Robert J. Parker, M.D., Bloomington
Caesar Portes, M.D., Chicago
Morris Profitt, M.D., Chicago
Will Rasmussen, Chicago
Edward F. Scanlon, M.D., Evanston
Berry Seng, M.D., Morris
Maynard Shapiro, M.D., Chicago
Reverend Reuben A. Sheares, II, Chicago
Hiram Sibley, Chicago
Kenneth E. Steffan, Chicago
John C. Troxel, M.D., Chicago
Charles Turner, Chicago
Sheldon Wallach, D.D.S., Glenwood
The Honorable James Walton, Chicago
J. A. Wells, M.D., Maywood
Franklin D. Yoder, M.D., M.P.H., Springfield

Number in parenthesis indicates number of beds in hospital. Initial preceding number refers to the type of control, as follows:

A—Corporation
B—Non-profit association or corporation
C—Privately owned and operated
D—City
E—County
F—Hospital District
G—Sanitarium District
H—Township
I—State
J—Federal

HOSPITALS WITH SPECIAL TYPE OF SERVICE

		Type of Service
CHICAGO (Cook)	Booth Memorial Hospital (A-19)	Maternity
	Chicago Eye, Ear, Nose and Throat Hospital (B-37)	EENT
	The Children's Memorial Hospital (A-240)	Pediatric
	Fox River Hospital (B-108)	Chronic
	Illinois Dept. of Public Health Hosp. & Clinics	Chronic
	LaRabida Children's Hospital and Research Center (A-104)	Pediatric Chronic
	Martha Washington Hospital (B-42)	General Alcoholic
	Municipal Contagious Disease Hospital (A-201)	Contagious Disease
	Municipal Tuberculosis Sanitarium (B-620)	TB
	Rehabilitation Institute of Chicago (B-71)	Rehabilitation
	Schwab Rehabilitation Hospital (B-88)	Rehabilitation
	Shriners Hospital for Crippled Children (A-68)	Orthopedic, Pediatric
FAIRVIEW HEIGHTS (St. Clair)	Pleasant View Seth Sanatoriam (B-25)	TB
HINSDALE (Cook)	The Suburban Cook County Tuberculosis Sanitarium District (B-153)	TB
MACKINAW (Tazewell)	Oak Knoll Sanatorium (E-32)	TB
MOOSEHEART (Kane)	Moosehart Hospital (B-43)	Pediatric
MOUNT VERNON (Jefferson)	Mount Vernon State Tuberculosis Sanitarium (B-73)	TB
OAK FOREST (Cook)	Oak Forest Hospital (E-2,211)	Chronic
OTTAWA (LaSalle)	Ottawa General Hospital (B-51)	Chronic
PEORIA (Peoria)	Peoria Municipal Tuberculosis Sanitarium (D-57)	TB
ROCK ISLAND (Rock Island)	Rock Island County Health Center (E-54)	TB
SPRINGFIELD (Sangamon)	St. John's Sanatorium (B-65)	TB
URBANA (Champaign)	Outlook Champaign County Tuberculosis Sanatorium (E-25)	TB
WAUKEGAN (Lake)	Lake County Tuberculosis Sanatorium (E-90)	TB
WEDRON (LaSalle)	St. Joseph's Health Resort and Sanitarium (B-97)	Medical-Chronic
WHEATON (Du Page)	Marianjoy, Inc.	Rehabilitation

STATE MENTAL HEALTH FACILITIES

ALTON (Madison)
Alton State Hospital

ANNA (Union)
Anna State Hospital

CENTRALIA (Madison)
Warren G. Murray Children's Center

CHAMPAIGN (Champaign)
Herman M. Adler Zone Center (Children)

CHESTER (Randolph)
Illinois Security Hospital

CHICAGO (Cook)
Chicago-Read Mental Health Center
Illinois Mental Health Institutes
Illinois State Pediatric Institute
Illinois State Psychiatric Institute
Institute for Juvenile Research

DECATUR (Macon)
Adolf Meyer Zone Center (Adults)

DIXON (Lee)
Dixon State School

DWIGHT (Livingston)
William W. Fox Children's Center

EAST MOLINE (Rock Island)
East Moline State Hospital

ELGIN (Kane)
Elgin State Hospital

GALESBURG (Knox)
Galesburg State Research Hospital

HARRISBURG (Saline)
A. L. Bowen Children's Center

HINES (Cook)
John J. Madden Mental Health Center

JACKSONVILLE (Morgan)
Jacksonville State Hospital

KANKAKEE (Kankakee)
Kankakee State Hospital

LINCOLN (Logan)
Lincoln State School

MANTENO (Kankakee)
Manteno State Hospital

PARK FOREST (Cook)
Elisabeth Ludeman Center

PEORIA (Peoria)
Peoria State Hospital
George A. Zeller Zone Center

ROCKFORD (Winnebago)
H. Douglas Singer Zone Center

SPRINGFIELD (Sangamon)
Andrew McFarland Zone Center

TINLEY PARK (Cook)
Tinley Park Mental Health Center

LICENSED CLINICAL LABORATORIES

**Indicate Medicare Certified*

ALTON
*Stromsdorfer Medical Laboratory
604 E. Broadway, Rm. 101 62002

ARGO
*Argo Clinical Laboratory
6252 Archer Road 60501

ARLINGTON HEIGHTS
*Village Medical Laboratory
1009 S. Evergreen 60005
*Arlington Medical Laboratory
1430 N. Arlington Heights Road 60004
Respiratory Laboratory
1430 N. Arlington Heights Road 60004

AURORA
*Aurora Clinical Laboratory
143 South Lincoln 60505

BARRINGTON
Barrington Medical Laboratory
606 S. Northwest Hwy. 60010

BELLEVILLE
*St. Slair Medical Laboratory, Inc.
301 W. Lincoln Street 62221

BENTON
Benton Medical Center Laboratory
205 Bailey Lane 62812

BERKELEY, CALIFORNIA
Solano Laboratories, Inc.
2920 Telegraph Ave. 94705

BERWYN
Cermak Road Medical Laboratories
7120 W. Cermak Road 60402
Public Health District, Town of Berwyn
6600-26th Street 60402
Stickney Public Health District Laboratory
6721 West 40th Street 60402

BLOOMINGTON
*Bloomington Cornbelt Bio-Chemical, Inc.
705 North East 61701
McLean County Med. Assoc. Lab
326 Fairway Drive, Bloomington, 61701

BOSTON, MASS.
Clin-Chem Labs., Inc.
1106 Commonwealth Ave. 02215

BROADVIEW
*Broadview Physicians Laboratory
2200 W. Roosevelt Rd. 60153

CANTON
Coleman Clinic Laboratory
175 South Main 61520

CENTRALIA
Centralia X-ray Laboratories
418 South Poplar 62801

CHAMPAIGN
*Doctors Building Laboratory
301 E. Springfield 61820
Medical Arts Laboratory
302 E. Stoughton 61820

CHICAGO
*A & D Medical Laboratory, Inc.
6158 S. Pulaski Rd. 60629
Abel Laboratory, Inc.—Bio-Tech.
25 E. Washington St. 60602
*Almar Clinical Laboratory
2457 W. Peterson Ave. 60645
American Clinical Testing Laboratory
30 W. Washington St. 60602
*Antillas Medical Laboratory
3109 W. Armitage Ave. 60647
*Arcade Clinical Laboratory
6409 N. Sheridan Rd. 60626
Archer Clinical Laboratory
4176 Archer 60632
*Associated Medical Laboratory, Inc./Murphy Uptown
4753 N. Broadway 60640
*Auburn Clinical Laboratory
946 West 79th Street 60620
Augusta Clinical Laboratory
3454 N. Lincoln Ave. 60657
*Avenue Medical Laboratory
11318 S. Michigan Ave. 60628
Beverly Clinical Laboratory
9451 South Hoyne 60620
*Beverly Sheridan Laboratory
9449½ S. Ashland Ave. 60620
*Brooks Clinical Laboratory
4006 Milwaukee Avenue 60641
Clara Bruce, M.D.-Laboratory
5679 W. Madison St. 60644
*Aaron S. Cahan, M.D. Laboratory
4010 W. Madison Street 60624
*Campos Laboratory
1608 N. Milwaukee 60647
Central Diagnostics, Ltd.
30 N. Michigan Ave. 60602
Central Medical Building Laboratory
3929 N. Central Ave. 60634
*Chatham Avalon Clinical Laboratory
8222 S. Martin Luther King, Jr. Drive 60619
Chicago Board of Health—Division of Laboratories
Lower Level—Chicago Civic Center 60602
Chicago Health Center Laboratory
15 S. Wacker Drive 60606
*Chicago Medical Lab, Inc.
1518 N. Ashland Ave. 60622
Chicago Physicians Medical Laboratory, Inc.
4555 N. Broadway 60640
*Clearing Industrial Clinic
5548 W. 65th Street 60638
Clybourn Medical Laboratory
1322 N. Clybourn 60610
*Colonial Medical Arts Laboratory
2024 West 79th Street 60620
*Community Medical Laboratory
3613 W. Roosevelt Rd. 60624
Continental Insurance Company
360 W. Jackson Blvd. 60606
Crawford Medical Arts Laboratory
6449 S. Pulaski Road 60629
*Cytodiagnostic Laboratory, Inc
25 E. Washington 60602
*Division Medical Laboratory, Inc.
2625 W. Division St. 60622
Division Clinical Laboratory
5025 W. Division St. 60651
Doctors Building Laboratory
2800 West 87th 60652
*Doctors Medical Laboratory, Inc.
11440 S. Michigan Ave. 60628
Duke Laboratories
4846 W. Chicago Ave. 60651
E & M Medical Labs, Inc.
2600 So. Michigan Ave. 60616
Field Clinic Laboratory
4600 N. Ravenswood Ave. 60640
Fordon Medical Laboratory
2656 W. 63rd Street 60629
*Foster Western Laboratories, Inc.
5214 N. Western Ave. 60625
Francis Laboratory
122 S. Michigan Ave. 60603
*Garco Med & X-Ray Lab., Inc.
933 W. Belmont 60657
*Garfield Medical Laboratories
818 W. Garfield Blvd. 60609
*Gerber X-Ray and Clinical Laboratory
2400 West Devon 60645

*Gerson Clinical Laboratories
1016 N. Ashland 60622

Grant Hospital Laboratory
551 W. Grant Place 60614

*Highland Medical Laboratories Inc.
8348 S. Stony Island Ave. 60617

Highland View Medical Center
8556 S. Ashland Ave. 60620

*Humboldt Clinical Laboratory
2018 S. Ashland Ave. 60608

Hyde Park Medical Laboratory
5240 South Harper 60615

International Clinical Lab., Inc.
2165 N. Milwaukee 60647

Irving Park Clinical Laboratory
3959 N. Lincoln Ave. 60613

*Jeffrey Center Clinical Laboratory
200 E. 75th St. 60619

K & K Clinical Laboratory
5935 W. Addison 60634

*Kendon Medical Laboratory, Inc.
8625 S. Cicero Avenue 60658

*Laboratory Associates Inc.
1200 N. LaSalle St. 60610

Laboratory of Union Health Service
1634 West Polk 60612

*Letho Clinical Laboratories
1325 S. Racine Avenue 60615

*Marquette Medical Laboratory
6132 South Kedzie 60629

Mason-Barron Laboratories, Inc.
Sub. of Damon Corporation
1525 E. 53rd St. 60615

*Mason-Barron Laboratories, Inc.
Sub. of Damon Corporation
55 E. Washington St. 60602

*Mason-Barron Pathology Clinical Laboratory
2056 North Clark Street 60614

*Medic Clinical Laboratory
6317 S. Western Avenue 60636

*Medical Associates of Chicago Clinic Laboratory
3233 South King Drive 60616

*Medical Center Clinical Laboratory
3528 N. Ashland Ave. 60657

Mediscreen Laboratory
5 South Wabash 60603

*Midwest Cytology Laboratory, Inc.
5707 North Ashland 60626

*Molay Medical Laboratory
185 North Wabash 60601

*North Kimball Medical Laboratory
3347 W. North Ave. 60647

*Northwest Medical Laboratories
1802 West Chicago 60622

*Norven Medical Laboratories Inc.
1816 W. Irving Park Road 60613

*Norwest Medical Laboratory
2336 West Chicago 60622

*Ogden Hill Medical Laboratory
3451 West 63rd Street 60629

*Omens Medical Building X-Ray and Clinical Laboratory
5720 West North Avenue 60639

*P-M Clinical Laboratories
155 E. Ohio St. 60611

*P. M. D. Clinical Laboratory
2017 West 95th Street 60643

*Parke DeWatt Laboratories, Inc.
111 North Wabash Ave. 60602

Parkside Clinical Laboratory
7915 S. King Drive 60619

*Parkway Laboratory
408 E. Marquette Road 60637

*Pathology Lab, Harry H. Hetz, M.D.
5040 N. Pulaski Rd. 60630

* Peterson Clinical Laboratory
2424 West Peterson 60645

Physical Measurements, Inc.
2320 W. Peterson 60645

Plaza View X-Ray and Lab., Inc.
2715 North Central Ave. 60639

*Post Graduate Hospital Laboratory
2400 S. Dearborn Street 60616

Preventi-Med Miltitest Center
155 E. Ohio St. 60611

*S & S Medical Laboratory, Inc.
532 East 47th Street 60653

*Sarian Medical Laboratory
6257 South Archer Ave. 60638

*Sauganash X-Ray and Medical Laboratory, Inc.
4833 W. Peterson 60646

*South Central Medical Laboratory
5050 South State 60609

Southwestern Laboratory, Inc.
7939 S. Western Avenue 60620

Tenco Hydro-Aerosciences Inc.
4921 S. Archer Ave. 60632

Thompson X-Ray and Clinical Laboratory
1150 North State Street 60610

*Thornburg Clinical Laboratory
841 East 63rd Street 60637

*Thornburg Clinical Laboratory
720 N. Michigan Ave. 60611

Richard W. Tiecke, D.D.S.
211 E. Chicago Avenue 60611

*United Medical Laboratories, Inc.
8 S. Michigan Ave., Room 1412 60603

*University Laboratory
5 South Wabash Avenue 60603

*Victoria Laboratories, Ltd.
5872 N. Milwaukee Ave., Suite B 60646

*West Lawn Medical Laboratory
4255 West 63rd Street 60629

*Westridge Clinical Laboratory
6450 N. California 60645

*Westside Clinical Laboratory
3808 W. Roosevelt Rd. 60624

*Zeitlin X-Ray and Clinical Laboratory
2800 Milwaukee Avenue 60618

*63rd Medical Laboratory
749 West 63rd Street 60621
Mal Mar Medical Bldg.
6333 S. Green St. 60621
*95th Street X-Ray and Clinical Laboratory
243 West 95th Street 60628
*2011 Medical Lab
2011 E. 75th St. 60619

CLAYTON, MISSOURI
Cooper Medical Laboratory
141 North Meramec 63105

COLLINSVILLE
Appleton Laboratory
416 E. Main Street 62201

COLUMBUS, OHIO
Automated Med. SV. of Ohio, Inc
1466 South High St., 43207

DALLAS, TEXAS
Bio-Assay, Lab., Inc.
7035 Carpenter Freeway, Box 6113 75222

DAVENPORT, IOWA
Quad-Cities Pathologists Group
125 Kirkwood Blvd. 52803
Quad-Cities Pathologists Group
1814 East Locust 52803

DECATUR
*Central Clinical Laboratory
1314 North Main 62526
Macon County Health Department Laboratory
1085 South Main Street 62521

DEKALB
DeKalb Public Hospital
720 Haish Boulevard 60115
*DeGraffenried Fisher Laboratory
1838 Sycamore Road 60115
DeKalb Medical Center Laboratory
901 North First Street 60115

DES PLAINES
*Dempster-Lyman Clinical Laboratory and X-Ray
2404 Dempster 60016
*DeRidge Clinical Laboratory
3200 Dempster Street 60016
*Fahey Medical Center
581 Golf Road 60016
Physical Measurements Inc.
8700 West Dempster, Des Plaines 60016

DETROIT, MICHIGAN
Central Laboratories, Inc.
17731 East Warren Ave.

DOWNERS GROVE
*Downers Grove Medical Laboratory
4333 Main St. DG. 60515

DUBLIN, OHIO
Consolidated Bio-Medical Lab, Inc.
6370 Wilcox Road 43017

EAST ST. LOUIS
*Appleton Laboratory
8787 State St. 62203
*Clinical Laboratories of St. Louis, Inc.
4601 State Street 62205

ELGIN
*Fox Valley Medical Laboratory
860 E. Summit Street 60120

ELMHURST
*Haven Clinical Laboratory
103 Haven Road 60126
Elmhurst Pathology Associates, S.C.
135 South Kenilworth 60126
*Mason-Barron Laboratories Inc.
Sub. of Damon Corporation
533 W. North Ave. 60126
Physical Measurements, Inc.
188 Industrial Drive, Room 120 60016
*Sandahl Medical Laboratory
135 S. Kenilworth 60126

ELMWOOD PARK
*Austin Clinical Laboratory
7830 W. North Ave. 60635

EVANSTON
*Cos Building Laboratory
2500 Ridge Avenue 60201
*Gyne-Cytology Laboratory, Inc.
636 Church Street 60201
Evanston-North Shore Health Dept.
Box 870 60201
*1101 Clinical Laboratory
1101 Howard Street 60202
*Mason-Barron Laboratories, Inc.
Sub. of Damon Corporation
636 Church Street 60201

EVANSVILLE, INDIANA
Mid-America Pathology Serv. Inc.
3700 Bellemeade Avenue 47715

EVERGREEN PARK
*Anatomic and Clinical Pathology, Ltd.
P.O. Box 42919 60642
Evergreen Park Medical Laboratory
9760 South Kedzie Ave. 60642
*Francisco Medical Laboratory
9450 S. Francisco Ave. 60642
Mosquera Clinical Laboratory
3830 West 95th Street 60642
*North Beverly Clinical Laboratory
3759 West 95th Street 60642
Physical Measurements, Inc.
9730 S. Western Ave. 60642

FOREST PARK
*Bowers Laboratory
7318 Madison Street 60130

FRANKLIN PARK
*Franklin Park Medical Laboratory, Inc.
9711 Grand 60131

FREEPORT
Freeport Clinic S.C.
222 W. Exchange Street 61032
Freeport Medical Clinic
3103 West Stephenson Road 61032
*Northwest Illinois Laboratory
319 North West Avenue 61032

GALESBURG
*Galesburg Clinic Laboratory
320 N. Kellogg Street 61401

GLEN ELLYN
Glen Ellyn Clinic Laboratory
454 Pennsylvania Avenue 60137

GLENVIEW
*Northwest Suburban X-Ray and Clinical Laboratory
924 Waukegan Road 60025

GRAND RAPIDS, MICHIGAN
Continental Bio-Cln. Laboratory SV. Inc.
2823 Clydon S.W. 49509

GRANVILLE
*Physicians Clinical Laboratory 61326

HACKENSACK, NEW JERSEY
Metpath, Inc.
60 Commerce Way 07606

HAMMOND, INDIANA
Physicians Laboratory
5246 Hohman Ave. 46320

HARVEY
Community Medical Center S.C.
15900 Carol Avenue 60426
*Graham Clinical Laboratory
468 East 147th Street 60426
Weiss Medical Complex, Ltd.
15643 Lincoln Ave. 60426

HIGHLAND PARK
Clinical Bio-Tox Labs., Inc.
1436 Old Skokie Rd. 60035
*Mason-Barron Laboratories Inc.
Sub. of Damon Corporation
1950 Sheridan Road 60035

HINSDALE
*Colton Microbiology Laboratory
550 N. Monroe St. 60521
*Mason-Barron Laboratories Inc.
Sub. of Damon Corporation
40 S. Clay 60521

JACKSONVILLE
Medical Development Corporation
1440 West Walnut 62650

JERSEYVILLE
*Miller Medical Laboratory
123A West Pearl Street 62052

JOLIET
*Associate Pathologists of Joliet Ltd.
2112 West Jefferson 60435
*Central Laboratory
57 W. Jefferson Street 60431
Clinical Diagnostics Inc.
1013 Panes Ave., Suite #3 60435
*Osler Laboratories, Inc.
120 North Scott Street 60431
*Joliet Prescription Shops, Inc. Lab
55 N. Ottawa Street 60431

KANKAKEE
*Medical Center Laboratory
1309 East Court Street 60901
*Westwood Medical Lab
401 North Wall 60901

LAGRANGE
*LaGrange Medical Building Laboratory
47 South Sixth 60525

LAGRANGE PARK
Village Market Medical Laboratory
360 Sherwood Court 60525

LASALLE
Hygienic Institute Laboratory
151 Fifth Street 61301
*Medical Laboratory
555-2nd Street 61301

LANSING
*DeGraff Clinical Laboratory
3341 Ridge Road 60438
*Labreco Inc.
3341 Ridge Road 60438
Physical Measurements, Inc.
18225 Burnham Avenue 60438

LEROY
V. K. Pliura, M.D. Laboratory
101 West School 61752

LOMBARD
Lombard Chiropractic Clinical Lab
200 E. Roosevelt Rd. 60148
*Myer, Meyer & Albers, S.C.
815 So. Main 60148

LOUISVILLE, KENTUCKY
Clinical Diagnostic Labs, Inc.
634 So. Floyd St. 40202

MACOMB
Winter and Rettenmaier
Professional Corporation
McDonough Dist. Hospital
525 E. Grant Street 61455

MANSFIELD, OHIO
Automated Medical Service of Ohio, Inc.
666 Park Ave. West 44906

MARSEILLES
Carr Medical Laboratory
Main Street 61341

MAYWOOD
*Joslyn Clinic Laboratory
1908 St. Charles Road 60153

MCHENRY
*McHenry Medical Group
1110 N. Green Street 60050

MELROSE PARK
*Delm Medical Laboratory
1812 Broadway 60160

MEMPHIS, TENN.
Moss-Farrow Pathology Lab
257 So. Bellevue 38104

MENDOTA
Mendota Community Hospital Laboratory
Memorial Drive 61342

METUCHEN, N.J.
Center for Lab Medicine
16 Pearl St. 08840

MILWAUKEE, WIS.
Bio-Medical Laboratories
811 E. Wisconsin Ave. 53202
Drug I.D. Laboratory, Inc.
4608 W. Burleigh St. 53210

MOLINE
*Martin Clinical Laboratory
1520-7th Street 61265
Moline Public Hospital Laboratory
635-10th Avenue 61265
Quad-City Pathology Group
Lutheran Hospital 501-10th Avenue 61265

MORTON GROVE
*Sommerfeld Medical Laboratory, Inc.
5818 Dempster Street 60053

MOUNT PROSPECT
*Mount Prospect Clinical Laboratory
321 West Prospect Ave. 60056
Med. Analytics Reference Lab
530 W. Northwest Hwy. 60056
*Professional Arts Medical Laboratory
601 West Central Rd.

NEW ALBANY, INDIANA
Physician's Precision Automated Labs, Inc.
1919 State Street 47150

NEW YORK, N.Y.
Continental Research Institute, The
25 Cedar St. 10038

NORMAL
*Stroink Pathology Laboratories
900 Franklin Avenue 61761

NORTHBROOK
*A & M Clinical Laboratory
1500 Shermer Road 60062
Industrial Bio-Test Laboratories, Inc.
1810 N. Frontage Road 60062
*Northbrook Clinical and X-Ray Laboratory
1775 Walters 60062

NORTH HOLLYWOOD, CALIF.
Bio-Chemical Procedures
12020 Chandler Blvd. 91607
Reference Lab
12926 Saticoy St. 91605

OAKLAND PARK, FLORIDA
Broward Biocl. Lab. Div. of Damon
3290 N.E. 12th Ave. 33308

OAK LAWN
*American Medical Labs.
4817 W. 83rd St. 60459
Stickney Township Public Health Laboratory
5635 State Road 60459

OAK PARK
*American Medical Laboratory
6441 W. North Avenue 60302
*McGregor Laboratory
6144 W. Roosevelt Road 60304
*Hill Clinical Laboratory, Inc.
1011 Lake Street 60301

OLYMPIA FIELDS
Athenia Park Medical and X-Ray Laboratory
2601 W. Lincoln Hwy. 60461

PALOS HEIGHTS
*Palos Labs, Inc.
12742 S. Harlem Ave. 60463
Palos Medical Center Lab
12150 S. Harlem Avenue 60463

PARK FOREST
*South Suburban Medical Laboratory
2448 Western Avenue 60466

PARK RIDGE
Chrometrics Labs, Inc.
523 Talcott Road 60068
Trace Elements, Inc.
460 S. Northwest Hwy. 60068

PEORIA
*M. B. Clinical Laboratory Corp.
818 West Main 61606
*Medical Center Laboratories
416 St. Marks Court 61603
*Medical Laboratory, The
300 E. War Memorial Dr. 61614
Peoria City Department of Health
2116 N. Sheridan Road 61604

PORTLAND, OREGON
United Medical Labs., Inc. Sandy Annex
10700 N.E. Sandy Blvd. 97220
United Medical Labs., Inc. Toxicology Lab.
10005 N.E. Sandy Blvd. 97220
United Medical Labs., Inc. Exfoliative Cytology Lab.
10035 N.E. Sandy Blvd. 97220
United Medical Labs., Inc. Lipid Lab.
10504 N.E. Sandy Blvd. 97220
United Medical Labs., Inc
6060 N.E. 112th 97208

ROCKFORD
*Medical Labs of Pathology
1221 E. State Street 61108
Winnebago Co. Health Dept. Lab
401 Division St. 61108

ROLLING MEADOWS
Rolling Meadows Professional Laboratory
3407 Kirchoff Road 60008

ROSELLE
Sylvester Clinical Laboratory
225 E. Irving Park Road 60172

SANDWICH
Sandwich Comm. Hospital Laboratory
11 East Pleasant 60548

SKOKIE
Erich L. Gibbs, Ph.D.
9701 N. Kenton Ave. 60076
*North Suburban Clinical Laboratory
4801 Church Street 60076
*Mason-Barron Laboratories Inc.
Sub. of Damon Corporation
64 Old Orchard 60076

SOUTH HOLLAND
*Avenue Medical Laboratory
16234 South Louis Ave 60473

SPRINGFIELD
*Capitol Clinical Laboratories
1104 South 2nd Street 62704
*Physicians Medical Laboratory
501 N. 6th-Box 2178 62703
*Springfield Clinic
1025 South 7th Street 62703
*University Medical Lab
901 North First St. 62702

STREATOR
Streator Medical Clinic, S.C.
Westgate Plaza 61364
Streator Medical Clinic. S. C.
S. Bloomington and 6th St. 62364

ST. LOUIS, MO.
Allen Medical Laboratories
2821 N. Ballas Road 63131
Clinical Labs. of St. Louis, Inc.
100 N. Euclid 63108
Clinical Labs. of St. Louis, Inc.
3720 Washington Blvd. 63108

Midwest Medical Laboratory, Inc.
4141 Forest Park Blvd. 63108
Misouri Clinical and Biochemical Lab, Inc.
4910 Forest Park Blvd. 63108
Pathology Services, Inc.
52 Maryland Plaza 63108

SAN DIEGO, CALIF.
Pap Smear Center, Inc.
4232 University Ave. 92105

SYCAMORE
Sycamore Municipal Hospital
225 Edward St. 60178

TEANECK, N.J.
Metropolitan Path. Lab., Inc.
185 W. Englewood Ave. 07666
Metpath, Inc.,
1002 Teaneck Road 07666

TINLEY PARK
*Affiliated Medical Laboratories
6785 W. 174th Street 60477

URBANA
Carle Clinic Laboratory
602 W. University 61801

UTICA
*C. W. Atherton M.D. Laboratory
Rural Route #1 61373

VAN NUYS, CALIF.
Bio-Science Labs.
7600 Tyrone Ave. 91405

VILLA PARK
*Ardmore Pharmacy, Inc.
317 S. Ardmore 60181

Villa Medical Arts Laboratory
10 E. Central Blvd. 60181

WAUKEGAN
*Physicians and Surgeons Laboratory
1616 Grand Avenue 60085
Standard Bio-Medical Laboratories, Inc.
1745 Hickory St. 60085

WESTBURY, NEW YORK
Biochemex Lab/Damon
800 Shames Dr. 11590

WHEATON
*Mason-Barron Pathology Laboratory, S.C.
200 E. Willow 60187

WICHITA, KANSAS
Associated Labs, Inc.
5111 E. 21st St. 67208

WILMETTE
*Wilmette Clinical Laboratory
165 Green Bay Road 60091

WILMINGTON
Clinical Laboratory and X-Ray
107 S. Water Street 60481

WINNETKA
*Clini-Tech Labs, Inc.
907 Linden 60093
*Winnetka Clinical Laboratory
725 Elm Street 60093

WOODLAND HILLS, CALIF.
Lab Procedures-Div. of Upjohn Company
6330 Variel Dr. 91364

ZION
*Zion Clinic
3115 Lewis Ave. 60099

*Medicare Certified

APPROVED RENAL DIALYSIS FACILITIES, CENTERS AND DIRECTORS
Illinois Department of Public Health
Division of Chronic Illness

Michael Reese Hospital and Medical Center
29th Street and Ellis Ave., Chicago 60616
Alan Kanter, M.D.

Presbyterian-St. Luke's Hospital
1753 West Congress Parkway, Chicago 60612
Todd S. Ing, M.D.

Chromalloy American Kidney Center
(Barnes Hospital)
4949 Barnes Hospital Plaza, St. Louis, Mo. 63110
Eduardo Slatopolsky, M.D.

Memorial Hospital
First and Miller Sts., Springfield 62701
Alton Morris, M.D.

Evanston Hospital
2650 Ridge Ave., Evanston 606201
Bernard Adelson, M.D.

University Hospitals
Department of Medicine
1300 University Ave., Madison, Wis. 53706
Arvin B. Weinstein, M.D.

University of Illinois Research and Educational Hospitals
840 South Wood St., Chicago 60612
Franklin Schwartz, M.D.

Mayo Clinic
Internal Medicine & Nephrology, Rochester, Minn. 55901
William J. Johnson, M.D.

University of Chicago Hospitals & Clinics
(Includes LaRabida Sanitarium)
950 East 59th St., Chicago
Edmund Lewis, M.D.

Mount Sinai Hospital Medical Center
Fifteenth and California Aves., Chicago, 60608
Earl C. Smith, M.D.

Northwestern Memorial Hospital
Superior and Fairbanks Ct., Chicago 60611
Francesco del Greco, M.D.

West Suburban Hospital and West Suburban Kidney Center, Inc.
518 North Austin Blvd., Oak Park 60302

Rockford Memorial Hospital
2300 North Rockton Ave., Rockford 61101
Ewald T. Sorensen, M.D.
Cook County Hospital
1825 West Harrison St., Chicago 60612
George Dunea, M.D.

St. Francis Hospital
523 N. E. Glen Oak, Peoria 61603
Robert Pflederer, M.D.

APPROVED RENAL DIALYSIS UNITS AND DIRECTORS
Illinois Department of Public Health
Division of Chronic Illness

The Children's Memorial Hospital
2300 Children's Plaza, Chicago 60614
Peter R. Lewy, M.D.

Lake View Memorial Hospital
812 North Logan Ave., Danville 61832
Joseph G. Ellis, M.D.

Mercy Hospital
1400 West Park Ave., Urbana 61801
R. E. Tirona, M.D.

St. Joseph Hospital
2900 North Lake Shore Dr., Chicago 60657
Gordon Lang, M.D.

Galesburg Cottage Hospital
674 North Seminary St., Galesburg 61401
Agha Babanoury, M.D.

Roosevelt Memorial Hospital
426 West Wisconsin St., Chicago 60614
Franklin D. Schwartz, M.D.

Ingalls Memorial Hospital
15510 Page Ave., Harvey 60426
Alexander B. White, M.D.

Doctors Memorial Hospital
404 West Main St., Carbondale 62901
John Taylor, M.D.

Blessing Hospital
1005 Broadway, Quincy 62301
Hugh Espey, M.D.

Jefferson County Memorial Hospital
909 Shawnee St., Mount Vernon 62864
John M. Dunn, M.D.

Victory Memorial Hospital
1324 North Sheridan Rd., Waukegan 60085
John Freeland, M.D.

Central DuPage Hospital
0 North 025 Winfield Rd., Winfield 60190
Paul Balter, M.D.

Loyola University Hospital
2160 South First Ave., Maywood 60153
A. R. Lavender, M.D.

For further information contact:

Mrs. Ruth S. Shriner, ACSW—Coordinator Renal Disease Program, Illinois Department of Public Health
4398 South Jeffory St., Springfield 62761
Phone: (217) 786-6980

Dialysis for Veterans with kidney disease is available at·

Veterans Administration Hospital, Hines
A. R. Lavender, M.D.

Veterans Administration Research Hospital, Chicago
Peter Ivonovich, M.D.

ARTIFICIAL KIDNEYS FOR ACUTE POISONING CASES

Copley Memorial Hospital
Lincoln & Weston Avenues
Aurora
Phone: 897-6021
Person in Charge:
Location in Hosp: Intensive Care

St. Elizabeth's Hospital
211 S. 3rd Street
Belleville
Phone: 234-2120
Person in Charge:
Location in Hosp: Intensive Care

Children's Memorial Hospital
2300 Children's Plaza
Chicago
Phone: 348-4040
Person in Charge: Dr. Peter Lewy
Location in Hosp: Nephrology

Cook County Hospital
1835 West Harrison
Chicago
Phone: 633-6000
Person in Charge: Dr. George Dunea
Location in Hosp: Ward 25 South

Edgewater Hospital
5700 N. Ashland Avenue
Chicago
Phone: 878-6000
Person in Charge: Dr. Rogelio Riera
Location in Hosp: Surgery

Michael Reese Hosp. & Medical Center
29th & Ellis Avenue
Chicago
Phone: 791-2000
Person in Charge: Dr. Allan Kanter
Location in Hosp: Renal Division Department of Medicine

Mt. Sinai Hospital 15th & California Avenue Chicago	Phone: Person in Charge: Location in Hosp:	542-2000 Earl Smith, M.D. Medicine
Northwestern Memorial Hospital 303 E. Chicago Chicago	Phone: Person in Charge: Location in Hosp:	944-4200 Francesco delGreco, M.D. Dialysis Center
Rush-Presbyterian-St. Lukes 1753 West Congress Parkway Chicago	Phone: Person in Charge: Location in Hosp:	942-5000 Todd Ing, M.D. Division of Medicine
Roosevelt Memorial Hospital 426 W. Wisconsin Chicago	Phone: Person in Charge: Location in Hosp:	664-8000 Franklin Schwartz, M.D. Hemodialysis
University of Chicago Hospital 950 E. 59th Chicago	Phone: Person in Charge: Location in Hosp:	947-5255 Adrian Katz, M.D. Out Patient-Ambulatory Care
University of Illinois Hospital 840 S. Wood St. Chicago	Phone: Person in Charge: Location in Hosp:	663-6444 Franklin Schwartz, M.D. Medical Nephrology
Lake View Memorial Hospital 812 N. Logan Avenue Danville	Phone: Person in Charge: Location in Hosp:	443-5000 J. G. Ellis, M.D. Adjacent to ICU
St. Joseph Hospital 277 Jefferson Avenue Elgin	Phone: Person in Charge: Location in Hosp:	741-5400 William T. Sheehy, M.D. Artificial Kidney Dept.
Memorial Hospital of DuPage Co. 209 Avon Road Elmhurst	Phone: Person in Charge: Location in Hosp:	833-1400 J. J. Simonaitis, M.D. Dept. of Medicine
Evanston Hospital 2650 Ridge Avenue Evanston	Phone: Person in Charge: Location in Hosp:	492-2000 Bernard Adelson, M.D. Medicine-Section of Nephrology
Galesburg Cottage Hospital 674 N. Seminary St. Galesburg	Phone: Person in Charge: Location in Hosp:	343-4121 Agha Babanoury, M.D. Surgical Wing
Ingalls Memorial Hospital 15510 Page Avenue Harvey	Phone: Person in Charge: Location in Hosp:	333-2300 Alexander B. White, M.D. ICU—North V
Loyola University Hospital 2160 South 1st Avenue Maywood	Phone: Person in Charge: Location in Hosp:	531-3800 Luis Cespedes, M.D. Renal Dialysis
West Suburban Hospital 518 N. Austin Blvd. Oak Park	Phone: Person in Charge: Location in Hosp:	383-6200 Robert Muehrcke, M.D. Kidney Dialysis Center
St. Francis Hospital 530 N.E. Glen Oak Peoria	Phone: Person in Charge: Location in Hosp:	672-2000 R. A. Pflederer, M.D. Hemodialysis
Rockford Memorial Hospital 2400 N. Rockton Rockford	Phone: Person in Charge: Location in Hosp:	968-6861 E. T. Sorensen, M.D. Dept. of Medicine
Memorial Hospital 1st & Miller Springfield	Phone: Person in Charge: Location in Hosp:	528-2041 Alton J. Morris, M.D. Dr. Richard Bilinsky
Mercy Hospital 1400 West Park Urbana	Phone: Person in Charge: Location in Hosp:	337-2157 Mrs. Jean Porterfield, R.N. Mr. Michael Luth Nursing Service

In addition to the hospitals in Illinois, we have also received information that the following hospital has an artificial kidney. This out of state hospital may be more accessible in some emergencies than those in Illinois:

Barnes Hospital
Barnes Hospital Plaza
St. Louis, Missouri

Phone: 367-6400
Person in Charge: Dr. Edwardo Slatapolsky
Location in Hosp: Renal Division

POISON CONTROL CENTERS IN ILLINOIS

For further information contact:
Byron J. Francis, M.D., M.P.H.
Program Chief
Division of Disease Control
Illinois Department of Public Health
535 W. Jefferson
Springfield, 62761
Phone: (217) 525-2166

AURORA
Copley Memorial Hospital
Lincoln & Weston Avenues
897-6021, ext. 725

BELLEVILLE
Memorial Hospital
4501 North Park Drive
233-7750, ext. 250

BELVIDERE
Highland Hospital
1625 S. State St.
547-5441

BERWYN
MacNeal Memorial Hospital
3249 S. Oak Park Avenue
797-3000

BLOOMINGTON
Mennonite Hospital
807 North Main St.
828-5241 ext. 312
St. Joseph's Hospital
2200 E. Washington
662-3311, ext. 352

CAIRO
St. Mary's Hospital
2020 Cedar St.
734-2400

CANTON
Graham Hospital Association
210 W. Walnut St.
647-5240, ext. 248

CARBONDALE
Doctors Memorial Hospital
404 W. Main St.
457-4101

CARTHAGE
Memorial Hospital
End of South Adams St.
357-3131, ext. 57

CENTRALIA
St. Mary's Hospital
400 N. Pleasant Avenue
532-6731, ext. 629

CHAMPAIGN
Burnham City Hospital
407 S. 4th
337-2533

CHANUTE AIR FORCE BASE
United States Air Force Hospital
495-3133
Limited for treatment of military personnel and families, except for indicated civilian emergencies

CHESTER
Memorial Hospital
1900 State St.
826-4581

CHICAGO
Children's Memorial Hospital
2300 Children's Plaza
348-4040
Cook County Children's Hospital
700 S. Wood St.
633-6542
University of Illinois Hospitals
840 South Wood St.
996-6801
Mercy Hospital
2510 S. Prairie
842-4700, ext. 281
Michael Reese Hospital
2929 S. Ellis
791-2050
Mt. Sinai Hospital
15th & California
542-2030
Municipal Contagious Disease Hospital
3026 South California Avenue
247-5700
Rush-Presbyterian-St. Lukes Medical Center
(**Master Chicago Center** for information, treatment, and reference on poisonings)
1753 W. Congress Parkway
942-5969
Resurrection Hospital
7435 West Talcott Avenue
774-8000
Wyler Children's Hospital
950 E. 59th St.
947-6231

DANVILLE
Lake View Memorial Hospital
812 N. Logan Avenue
443-5221
St. Elizabeth Hospital
600 Sager Avenue
442-6300, ext. 647, 674

DECATUR
Decatur Memorial Hospital
2300 N. Edward St.
877-8121, ext. 676
St. Mary's Hospital
1800 E. Lakeshore Drive
429-2966, ext. 640

DES PLAINES
Holy Family Hospital
100 North River Road
297-1800

EAST ST. LOUIS
Christian Welfare Hospital
1509 Illinois Avenue
874-7076, ext. 232, 216
St. Mary's Hospital
129 North 8th St.
274-1900, ext. 204

EFFINGHAM
St. Anthony Memorial Hospital
503 North Maple St.
342-2121, ext. 211

ELGIN
St. Joseph's Hospital
277 Jefferson Avenue
741-5400, ext. 65-69
Sherman Hospital
934 Center St.
742-9800, ext. 682

ELMHURST
Memorial Hospital of DuPage County
209 Avon Road
833-1400, ext. 550, 551

EVANSTON
St. Francis Hospital
355 Ridge Avenue
492-2440
Community Hospital
2040 Brown Avenue
869-5400, ext. 54, 58
Evanston Hospital
2650 Ridge Avenue
492-6460

EVERGREEN PARK
Little Company of Mary Hospital
2800 W. 95th St.
422-6200

FAIRBURY
Fairbury Hospital
519 South Fifth St.
692-2346

FREEPORT
Freeport Memorial Hospital
420 South Harlem Avenue
233-4131, ext. 228

GALENA
The Galena Hospital
Summit Street
777-1340, ext. 35

GALESBURG
Galeburg Cottage Hospital
674 North Seminary St.
343-4121, ext. 356
St. Mary's Hospital
239 South Cherry St.
343-3161, ext. 210

GRANITE CITY
St. Elizabeth Hospital
2100 Madison Avenue
876-2020, ext. 401

HARVEY
Ingalls Memorial Hospital
15510 Page Avenue
333-2300, ext. 451, 452

HIGHLAND
St. Joseph's Hospital
1515 Main St.
654-2171, ext. 297

HIGHLAND PARK
Highland Park Hospital
718 Glenview Avenue
432-8000, ext. 561

HINSDALE
Hinsdale San & Hospital
120 North Oak St.
323-2100, ext. 336

HOOPESTON
Hoopeston Community Memorial Hospital
701 E. Orange St.
283-5531

JACKSONVILLE
Passavant Memorial Area Hospital
1600 West Walnut St.
245-9541

JOLIET
St. Joseph Hospital
333 N. Madison St.
725-7133, ext. 679, 680
Silver Cross Hospital
1200 Maple Road
729-7563

KANKAKEE
Riverside Hospital
350 N. Wall St.
933-1671, ext. 606
St. Mary Hospital
150 South Fifth Avenue
939-4111, ext. 735

KEWANEE
Kewanee Public Hospital
719 Elliott St.
853-3361, ext. 219

LAKE FOREST
Lake Forest Hospital
660 North Westmoreland
234-5600, ext. 608

LASALLE
St. Mary Hospital
1015 O'Conor Avenue
223-0607, ext. 14

LINCOLN
Abraham Lincoln Memorial Hospital
315 Eighth St.
732-2161, ext. 346

MACOMB
McDonough District Hospital
525 East Grant St.
833-4101, ext. 433

MATTOON
Memorial Hospital District of Coles County
2101 Champaign Avenue
234-8881, ext. 43

MAYWOOD
Loyola University Hospital
2160 S. 1st Avenue
531-3000

McHENRY
McHenry Hospital
3516 West Waukegan Road
385-2200, ext. 614

MELROSE PARK
Westlake Community Hospital
1225 Superior St.
681-3000, ext. 226

MENDOTA
Mendota Community Hospital
Route 51 and Memorial Drive
539-7461

MOLINE
Moline Public Hospital
635 - 10th Avenue
762-3651, ext. 232

MONMOUTH
Community Memorial Hospital
1000 W. Harlem Avenue
734-3141, ext. 224

MOUNT CARMEL
Wabash General Hospital
1418 College Drive
262-4121

MOUNT VERNON
Good Samaritan Hospital
605 North Twelfth St.
242-4600, ext. 303

NAPERVILLE
Edward Hospital
South Washington St.
355-0450, ext. 326

NORMAL
Brokaw Hospital
Virginia at Franklin Avenue
829-7685, ext. 274

OAK LAWN
Christ Community Hospital
4440 West 95th St.
425-8000, ext. 659, 660

OAK PARK
West Suburban Hospital
518 North Austin Blvd.
383-6200, ext. 6747, -48

OLNEY
Richland Memorial Hospital
800 East Locust St.
395-2131, ext. 226

OTTAWA
Ottawa Community Hospital
701 Clinton St.
433-3100, ext. 48

PARK RIDGE
Lutheran General Hospital
1775 Dempster St.
696-2210, ext. 1460

PEKIN
Pekin Memorial Hospital
14th & Court
347-1151, ext. 241

PEORIA
Methodist Hospital
221 N.E. Glen Oak Avenue
685-6511, ext. 250
Proctor Community Hospital
5409 North Knoxville Avenue
691-4702, ext. 791, 792
St. Francis Hospital
530 N.E. Glen Oak Avenue
672-2109

PERU
Peoples Hospital
925 West St.
223-3300, ext. 53, 55

PITTSFIELD
Illini Community Hospital
640 West Washington St.
285-2113, ext. 238

PRINCETON
Perry Memorial Hospital
530 Park Avenue, East
875-2811, ext. 311

QUINCY
Blessing Hospital
1005 Broadway
223-5811, ext. 255
St. Mary Hospital
1415 Vermont St.
223-1200, ext. 275

ROCKFORD
Rockford Memorial Hospital
2400 North Rockton Avenue
968-6861, ext. 441
St. Anthony Hospital
5666 E. State St.
226-2041
Swedish-American Hospital
1316 Charles St.
968-6898, ext. 602, 3, 4

ROCK ISLAND
Rock Island Franciscan Hospital
2701 17th Street
793-1000

ST. CHARLES
Delnor Hospital
975 North Fifth Avenue
584-3300, ext. 229

SCOTT AIR FORCE BASE
USAF Medical Center
256-7363

SPRINGFIELD
Memorial Hospital
First and Miller Streets
528-2041, ext. 333
St. John's Hospital
701 E. Mason St.
544-6451, ext. 375

STREATOR
St. Mary's Hospital
111 E. Spring St.
673-2311, ext. 221

URBANA
Carle Foundation Hospital
611 W. Park St.
337-3311, 3100
Mercy Hospital
1400 W. Park Avenue
337-2131

WAUKEGAN
St. Therese Hospital
2615 West Washington St.
688-6470
Victory Memorial Hospital
1324 North Sheridan Road
688-4181, -82

WOODSTOCK
Memorial Hospital for McHenry County, Inc.
527 W. South St.
338-2500, ext. 232

ZION
Zion-Benton Hospital
Shiloh Boulevard
872-4561, ext. 240

PACKAGED DISASTER HOSPITALS IN ILLINOIS
Illinois Department of Public Health
Emergency Health Preparedness Section

4398 S. Jeffory, Springfield, 62707
PHONE: (217) 786-6974 or 6975

ALTON
St. Joseph's Hospital

ANNA
Anna State Hospital

AURORA
Copley Memorial Hospital

BELVIDERE
St. Joseph's Hospital

BENTON
Franklin Hospital

CAIRO
St. Mary's Hospital

CANTON
Graham Hospital

CARLINVILLE
Carlinville Hospital

CENTRALIA
St. Mary's Hospital

CHARLESTON
Community Memorial Hospital

CHESTER
Chester Memorial Hospital

CHICAGO HEIGHTS
St. James Hospital

DANVILLE
Lakeview Memorial
St. Elizabeth's Hospital

DECATUR
Decatur Memorial Hospital

DEKALB
DeKalb Public Hospital

DES PLAINES
Forest Hospital
Holy Family Hospital

DIXON
Dixon State School

EFFINGHAM
St. Anthony Hospital

ELGIN
Elgin State Hospital
Sherman Hospital

ELMHURST
DuPage Memorial Hospital

EVANSTON
St. Francis Hospital

FREEPORT
Freeport Memorial

GALESBURG
Cottage Hospital
Galesburg State Hospital

HARRISBURG
Harrisburg Hospital

HIGHLAND PARK
Highland Park Hospital

HILLSBORO
Hillsboro Hospital

JACKSONVILLE
Jacksonville State Hospital

JERSEYVILLE
Jersey Community Hospital

JOLIET
Silver Cross Hospital

KANKAKEE
Kankakee State Hospital
St. Mary's Hospital

LAKE FOREST
Lake Forest Hospital

LINCOLN
Abraham Lincoln Memorial Hospital

LITCHFIELD
St. Francis Hospital

MANTENO
Manteno State Hospital

MARION
Marion Memorial Hospital

McHENRY
McHenry Hospital

METROPOLIS
Massac Memorial Hospital

MONMOUTH
Monmouth Hospital

MORRIS
Morris Hospital

MURPHYSBORO
St. Joseph Memorial Hospital

NORMAL
Brokaw Hospital

OAK FOREST
Oak Forest Hospital

OAK LAWN
Christ Community Hospital

OTTAWA
Ryburn Hospital

PARIS
Paris Hospital

PEKIN
Pekin Memorial Hospital

PEORIA
St. Francis Hospital

PONTIAC
St. James Hospital

PRINCETON
Perry Memorial Hospital

QUINCY
St. Mary's Hospital

RED BUD
St. Clement's Hospital

ROCKFORD
Swedish-American Hospital

RUSHVILLE
Sara D. Cubertson Hospital

ST. CHARLES
Delnor Hospital

SANDWICH
Sandwich Community Hospital

STERLING
Community General Hospital

URBANA
Carle Hospital

WAUKEGAN
St. Therese

WATSEKA
Iroquois Hospital

WINFIELD
Central DuPage Hospital

ZION
Zion-Benton Hospital

Medical Legal Information

(Prepared by ISMS Legal Counsel, James L. Fletcher)

The purpose of this article is to present the Illinois medical community with a general view of certain medical-legal principles and relationships which many physicians may encounter in the ordinary practice of their profession. Because this article is intended to provide information of a general nature only, specific problems should be discussed with one's individual attorney.

ISMS LEGAL SERVICES

The Illinois State Medical Society retains, on a continuing basis, a general counsel to whom the Society refers legal questions affecting the membership as a whole. ISMS also answers specific inquiries made by the component county medical societies when they are of general interest to the medical community. Although the Illinois State Medical Society cannot provide personal legal advice to individual members, the Society does believe the following information will help further each physician's awareness of certain basic legal principles and concepts vital to his practice.

THE PHYSICIAN-PATIENT RELATIONSHIP

Contractual Relationship

In most instances the physician-patient relationship is a voluntary, contractual one. Accordingly, physicians are required to accept only those patients they elect to treat. The professional services rendered on behalf of particular patients and the fees compensating the physician for those services are to be decided by the physician and the patient.

Whenever possible, the physician should discuss his fee with the patient in advance of treatment. If feasible, the understanding as to the fee should be reduced to writing as a permanent record for both parties. Not only does such a procedure minimize misunderstanding, but it may help to re-emphasize to the patient, and his carrier, the specific contractual duties that the patient has undertaken. In the absence of a specific fee agreement, a physician is entitled to "reasonable compensation" for services rendered by him.

While, as has been indicated above, a physician is free to determine who will be his patients, once the physician has undertaken the treatment of a particular patient, he is under a legal duty, subject to certain exceptions discussed below, to continue his attendance so long as the case requires attention. To disregard this duty may constitute negligence or malpractice on the part of the physician.

A physician may legally terminate his attendance of a particular case in several ways:

1. The contract between the physician and the patient expressly limits the scope of treatment;
2. The patient may discharge the physician;
3. The relationship may end by mutual consent;
4. The physician may legally terminate his services if the patient breaks the contract by failing to observe the medical directives of the physician.

In the event the patient fails to follow the physician's advice, the duties of the attending physician do not immediately terminate. Rather, the attending physician must provide the patient with sufficient, reasonable notice of his intention to withdraw, so as to enable the patient to secure another physician. This notice should be in writing and briefly explain to the patient the reason for the intended termination. If the patient returns to the attending physician, and has been unable to procure other medical assistance, the attending physician should *not* refuse continued treatment until a replacement has been secured.

HOSPITAL PATIENT RECORDS

Illinois law provides that every public and private hospital in the State shall, upon the written demand of any discharged patient, permit that patient's physician or authorized attorney to examine and make copies of his hospital records. These disclosure provisions do *not* apply in the case of a psychiatrist-patient relationship.

NEGLIGENCE LIABILITY OF PHYSICIANS

Illinois law requires physicians and surgeons to exercise that degree of reasonable skill as is used in ordinary good practice. The failure to exercise such skill will result in liability if the patient is thereby injured.

Recently, there has been a tendency (especially in the larger cities) to expand liability and to increase the amounts of recovery once liability has been established. When a sympathetic jury views an injured patient, it may well be inclined to interpret the facts in a manner detrimental to the physician. Although the "reasonable skill" standard is not unduly harsh, it is flexible enough to make its application in a particular lawsuit quite subjective.

While the legal implications in the field of malpractice litigation are numerous in scope, basically, the physician is liable for his own negligent acts and the negligent acts of all his employees. In the case of a partnership, he is also liable for the negligent acts of his partners.

Today there is simply no existing alternative to carrying adequate liability insurance. While the cost of various types of malpractice insurance coverage is costly and still increasing, it is nonetheless recommended that extremely high limits be maintained in one's policy.

In addition to purchase of malpractice insurance, each physician should attempt to conduct his practice in such a fashion that the initiation of (and the finding of "guilty" verdicts in) malpractice litigation is greatly minimized.

The American Medical Association has published and prepared for distribution a pamphlet entitled "Professional Liability and the Physician." Twenty guidelines

for preventing malpractice actions are set forth in that pamphlet:

1. The physician must care for every patient with scrupulous attention given to the requirements of good medical practice.

2. The physician must know and exercise his legal duty to the patient.

3. The physician must avoid destructive and unethical criticism of the work of other physicians.

4. The physician must keep records which clearly show what was done and when it was done, which clearly indicate that nothing was neglected, and which demonstrate that the care given met fully the standards demanded by the law. If any patient discontinues treatment before he should, or fails to follow instructions, the records should show it; a good method is to preserve a carbon copy of the physician's letter advising the patient against the unwise course.

5. A physician must avoid making any statement which constitutes, or might be construed as constituting, an admission of fault on his part. He should instruct employees to make no such statements.

6. The physician must exercise tact as well as professional ability in handling his patients, and should insist on a professional consultation if the patient is not doing well, if the patient is unhappy and complaining, or if the family's attitude indicates dissatisfaction.

7. The physician must refrain from over-optimistic prognoses.

8. The physician must advise his patients of any intended absences from practice and recommend, or make available, a qualified substitute. The patient must not be abandoned.

9. The physician must unfailingly secure an "informed" consent (preferably in writing) for medical and surgical procedures and for autopsy.

10. The physician must carefully select and supervise assistants and employees and take great care in delegating duties to them.

11. The physician should limit his practice to those fields which are well within his qualifications.

12. The physician must frequently check the condition of his equipment and make use of every available safety installation.

13. The physician should make every effort to reach an understanding with his patient in the matter of fees, preferably in advance of treatment

14. The physician must realize that it is dangerous to diagnose or prescribe by telephone.

15. The physician should not sterilize a patient solely for the patient's convenience, except after a reasonably complete explanation of the procedure and its risks and possible complications; and after obtaining a signed consent from the patient and from the patient's spouse, if the patient is married. Such sterilization is a crime in Connecticut, Kansas, and Utah and should not be performed in those states. Eugenic sterilization should be performed only in conformity with the law of the state, if any. Sterilization for therapeutic purposes may lawfully be performed with the informed consent of the patient and preferably with the informed consent of the patient's spouse, if the patient is married.

16. Except in an actual emergency situation which makes it impossible to avoid doing so, a male physician should not examine a female patient unless an assistant or nurse, or a member of the patient's family is present.

17. The physician should exhaust all reasonable methods of securing diagnosis before embarking upon a therapeutic course.

18. The physician should use conservative and less dangerous methods of diagnosis and treatment wherever possible, in preference to highly toxic agents or dangerous surgical procedures.

19. The physician should read the manufacturer's brochure accompanying a toxic agent to be used for diagnostic or therapeutic purposes and, in addition, should ascertain the customary dosage or usage in his area.

20. The physician should be aware of all the known toxic reactions to any drug he uses, together with the proper methods for treating such reactions.

In the October, 1971, issue of the *Illinois Medical Journal,* legal counsel to the Illinois State Medical Society expanded upon the recommendations of the AMA and urged that Illinois physicians also observe the following preventative safeguards:

1. Physicians should conduct their practice in hospitals so that they comply with, and live up to, the standards for hospital accreditation of the American Hospital Association, the hospital regulations adopted by the State Department of Public Health under the Hospital Licensing Act, and the by-laws of the hospital in which they are practicing.

2. Physicians should keep up on modern medicine in the fields in which they practice so they are conversant with and use the latest proven developments.

3. Physicians should call in specialists whenever the need arises.

4. Physicians should provide for automatic consultation in all serious cases—it cannot be disputed that any physician being called on to defend his treatment in court is in a much better position if he can also bring forth as a witness the physician who reviewed the case and consulted with him, or the specialist in a given field called in by him.

5. Hospital records and those of the physician should be kept in such manner and in such detail as will be meaningful and show that adequate medical procedures were followed. It should be remembered that cases frequently are not filed until some time after the alleged injury took place and sometimes do not come to trial for several years thereafter.

6. All cases should be treated in such a manner and records kept as if the case would result in a malpractice suit, and would not come to trial for a considerable period of time after the alleged injury had taken place.

7. Physicians should carry adequate malpractice insurance.

The Illinois State Medical Society has published a pamphlet, "The Physician's Liability in Patient Care," which is available for distribution to any physician who does not have a copy and desires one.

ILLINOIS CONTROLLED SUBSTANCES ACT

Under the recent Illinois Controlled Substances Act, physicians who dispense various controlled substances are required to register with the Illinois Department of Registration and Education. Categories of drugs under which registration is required are almost identical to those already established by the Federal Bureau of Narcotics and Dangerous Drugs.

LIMITS ON LIABILITY—SPECIAL SITUATIONS

The expansion of liability has not been of unqualified benefit to patients. Fear of legal reprisal may often inhibit the free exercise of professional judgment. This fact, in many situations, can work to the disadvantage of patients.

This realization has begun to find its way into the law. The Illinois General Assembly has become convinced that liability in specific situations should be limited so that medical personnel will be free to act without hesitation.

Under the "Good Samaritan" amendment to the Medical Practice Act, physicians who render emergency medical care in good faith and for no fee, at the scene of an accident, or in the case of a nuclear attack, are not liable for injuries resulting from their care unless they engage in wilful or wanton misconduct.

Similarly, a physician who serves on a medical review committee "shall not be liable for civil damages as a result of his acts, omissions or decisions in connection with his duties on such committee, except those involving wilful or wanton misconduct."

The Illinois General Assembly passed the "Hospital Emergency Service Act" (Senate Bill 1571) this past session and it has been signed into law. Basically, this law permits Illinois hospitals, with the approval of the Illinois Department of Public Health, to conduct pilot programs which utilize trained "mobile intensive care personnel" for the delivery of emergency medical care to the sick and injured at the scene of an emergency and during transport to a hospital. This law specifically provides that no physician who in good faith gives emergency instructions to mobile intensive care personnel at the scene of an emergency, shall be liable for any civil damages, unless issuing the instructions constitutes wilful or wanton misconduct.

AUTOPSY

In a recent Circuit Court of Cook County case, the court held that all relatives in the same class have property rights in the remains of a deceased person, and that each of them should give consent to an autopsy.

Illinois statutes permit authorization of an autopsy by any one member of a class of surviving relatives, unless any other relative with an equal right to make the decision objects, in writing or by telephone or telegraph. In the *Leno* case, however, the Court held the statute to be unconstitutional to the extent that it gives one member of a class of relatives authority to abrogate the rights of other members of the class.

It is unknown whether this ruling will be applied in other cases involving autopsies. Until the questions raised by this decision have been resolved, greater care is required in obtaining consents to autopsies, in order to avoid legal risks.

It is recognized that the performance of autopsies is necessary for maintaining adequate levels of postgraduate medical education in teaching hospitals under internship and residency programs approved by the Council on Medical Education of the American Medical Association. Performance of autopsies is necessary for the maintenance of high standards of patient care under the standards of the Joint Commission on Accreditation of Hospitals. *These necessities may justify the acceptance by hospitals and physicians of some calculated legal risks.*

Where it is virtually impossible to obtain the authorization from all persons who may have a right to decide—either because of the number of persons involved or because of the inaccessibility of some of them—hospitals and physicians may be willing to accept the calculated legal risk. This risk cannot be eliminated entirely, but it may be minimized to some extent by obtaining the written authorization by one or more adult children of the deceased patient or—if there are no adult children—the written consent of one or more adult brothers or sisters. Two such written consents would be preferable.

Although the calculated legal risk cannot be eliminated, it can be minimized by use of the suggested form found at the end of this article. For maximum protection against legal risks, autopsies should be performed only if consent is obtained from all members of the class of relatives who have the right to make the authorization.

The following is the suggested order for obtaining consent for autopsy:

1. If proper authorization for an autopsy is obtained from the spouse of the deceased patient, this is sufficient.

2. The consent of only one relative is also sufficient where there is no surviving spouse but one adult child, or no surviving spouse, children or parents, but one brother or sister. Where members of the same class of surviving relatives are more than one in number, such as several brothers and sisters, a consent should be obtained from each of them.

3. If there is no surviving spouse—and if there are no children, brothers or sisters of the deceased—consent by both parents of the deceased or by the surviving parent is sufficient.

4. If there is no surviving spouse, but the deceased has had children who either are alive or have died, without themselves having children, then the consent of all living adult children of the deceased is probably sufficient.

BIRTH CONTROL INFORMATION

Physicians are now specifically permitted to provide birth control services, including medical and pharmacological treatment and information, to any minor: a) who is married; or b) who is a parent; or c) who is pregnant; or d) who has the consent of his parent or legal guardian; or e) as to whom the failure to provide such services would create a serious health hazard; or f) who is referred for such services by a physician, clergyman or a planned parenthood agency.

MARRIAGE LICENSE EXAMINATION

Testing for Rubella immunity has been added to the VDRL test requirement for women applying for marriage licenses. Each woman must submit to the county clerk an affidavit signed by a licensed physician stating that he has *tested* her for rubella immunity or that a test has been ordered. The law does not require that the woman be immunized. If she is not immuned, she and her physician can decide the wisdom of immunization. Provisions are made in the law to exempt from the testing requirements women who object to immunization on religious grounds. (As of Oct. 3, 1972, some legal questions have arisen. Physicians should check with their county clerk.)

UNEMPLOYMENT COMPENSATION

The Illinois Unemployment Compensation law has recently been expanded so that it now includes coverage by physicians who employ only one person. This liability was discussed at some length in the "Practice Management" section of the July issue of the *Illinois Medical Journal*. If physicians have specific questions regarding the applicability of unemployment compensation to their employees, they should consult the Illinois Department of Labor, Division of Unemployment Compensation, or their attorney.

BLOOD LABELING

The new Illinois Blood Labeling Act requires that blood be labelled as either purchased or donated. Following July 1, 1973, the Act will forbid the use of purchased blood except as specifically permitted by the Illinois Department of Public Health.

SMALLPOX AND RUBELLA

During the past year two packages of legislation were enacted affecting Illinois immunization policy. One set of bills struck smallpox from the list of communicable diseases against which children must be immunized. This does not preclude immunization, on a permissive basis, if the physician and his patient determine that such immunization is best.

The second package of legislation added rubella to the list of diseases against which there is to be immunization. The Illinois Department of Public Health is beginning a program to achieve complete immunization among pre-school age children.

MEDICAL CORPORATIONS

Until 1963, when the Illinois General Assembly passed the Medical Corporation Act, physicians were not able to avail themselves of the legal advantages of doing business as a corporation. Historically, a primary reason for forbidding the use of the corporate form for doctors was that the personal assets of a corporation's stockholders were traditionally beyond the reach of creditors, including persons injured by the agents of the corporation. Because the public wished to insure itself of the best medical care, the law would not permit doctors to insulate themselves from personal malpractice liability.

The corporate form did, however, present certain advantages, particularly in the area of taxation, for which there was no compelling reason to discriminate against professionals. Throughout the past two decades the tax statutes of various professional medical corporations were thrashed out among the Internal Revenue Service, the Federal courts and professionals who claimed that their businesses were entitled to be taxed as corporations. Although many legal questions still remain unresolved, it is now reasonably certain that physicians in Illinois can take advantage of the corporate form.

Under the Illinois law, all the shareholders, officers and directors of a medical corporation must be licensed physicians. The corporation must register with the Illinois Department of Registration and Education under whose auspices it is permitted to operate. This law explicitly denies physicians working within a corporation the right to insulate their personal assets from malpractice liability.

Tax consequences are the primary factors in determining the wisdom of incorporation. In an article written for the November, 1970, issue of the *Illinois Bar Journal* Linscott R. Hanson summarized the advantages and disadvantages of incorporation. Among the major *advantages* listed, were:

1. Deductability by employees of a portion of their sick pay.
2. Deductability as a corporate business expense of the full cost of employee accident and health insurance.
3. Deductability as a corporate business expense of medical payments in excess of insurance.
4. Lower corporate tax rates for funds to be re-invested in the business.
5. Relatively easy adjustment of ownership percentages.
6. Avoidance of many probate problems upon the death of a practitioner and the avoidance of having to create a whole new business as when a partner dies.
7. Liability limitation, other than for malpractice, to the investment in the corporation thus reducing investors' risks.
8. Miscellaneous pension and profit-sharing tax advantages.

The disadvantages listed by Hanson included:

1. Possible legal costs in defending, to the Internal Revenue Service, the corporate status.
2. An increase of up to 25% for Social Security costs.
3. Corporate franchise taxes.
4. Possible subjection in fact to capital stock and personal property taxes.
5. Increased administrative and legal costs.
6. Increased state income tax payments.
7. State licensing fees.
8. Subjection to a host of State and Federal regulations of corporations.

Certainly each practitioner, physician and partnership should consider the merits of incorporating. The purpose here has been to give a brief explanation so that each interested physician can receive a general over-view of his options. A tax specialist should, of course, be consulted to review the particulars of each business situation.

FORMS

The following forms are submitted for possible use by Illinois physicians. Of course, one's attorney should be consulted where a particular situation appears sufficiently out of the ordinary to warrant a modification of the standard form.

ANATOMICAL GIFT ACT

Illinois law allows an individual to leave his body, or particular parts thereof, for medical science by means of his will or a written statement carried upon his person or found among his effects. The next of kin may also donate all or any part of the body for medical science. The Illinois law, authorizing the above, is set out at Paragraphs 551 through 560 of Chapter 3, Illinois Revised Statutes, 1971.

The Illinois State Medical Society has prepared forms which may be used by both the donor himself or by the next of kin. Copies of these forms are available at headquarters office in Chicago.

Anatomical Gift By a Living Donor

(1)
I, ..., do hereby give
(2)
..... to
(3)
..... for the following
(4)
purpose:

.....

IN WITNESS WHEREOF, I have hereunto set
(5)
my hand and seal this day of, A.D. 19———.

(6)
.....(SEAL)

Signed, sealed, published and declared by the
(1)
said in the presence of us, who at his (her) request, in his (her) presence and in the presence of each other have hereunto subscribed our names as attesting witnesses, believing him (her) to be of sound and disposing mind and memory, free from any undue influence, and to know the objects of his (her) bounty and affection.

(7)

(7)

Instructions

1. Insert name of person making gift.
2. Insert: "my whole body"; or list specific organs and parts to be given.
3. Insert name and address of a physician or a hospital, or a medical institution to receive the gift.
4. Insert: "any purpose authorized by law;" or "a transplantation" or "therapy;" or "research;" or "medical education."
5. Insert date of the signing of this card.
6. Signature of donor.
7. Signature and address of two necessary witnesses.

Anatomical Gift by Next of Kin Or Other Authorized Person

I. I (we) are the surviving:
- 1. ☐ Spouse and adult sons and daughters
- 2. ☐ Both parents or surviving parent
- 3. ☐ Adult brothers and sisters
- 4. ☐ Guardian of the person of the decedent
- 5. ☐ Person authorized or under obligation to dispose of the body

of, who died on the day of, 19..... in the County of, State of; and

II. I (we) hereby give:
- ☐ The entire body of the deceased.
- ☐ Any specific organs or parts of the body of the deceased designated by the donee.
- ☐ The following organs or parts of the body of the deceased:

.....

TO:
(Insert name and address of a physician; a hospital; or a medical institution)

for one of the following purposes:
- ☐ Any purpose authorized by law.
- ☐ A transplantation.
- ☐ Therapy.
- ☐ Research.
- ☐ Medical education.

REQUEST FOR ORAL CONTRACEPTIVE AGENTS

I, ..., hereby request Dr. to prescribe oral contraceptive agents for me.

It has been explained to me, and I fully understand, that the taking of oral contraceptives for contraception or other medical conditions for which their use may be indicated may have an adverse effect on me by the development of side effects in that there is a possibility that the use of such contraceptives may induce a tendency to blood clots, high blood pressure, liver disease, cancer and other diseases or injuries to my person.

After considering all of the items set forth above, and the possibility of harmful results from the use of the oral contraceptives, it is still my desire that such oral contraceptives be prescribed for me and I hereby assume any and all risk in connection therewith. I further agree that the said doctor is released from any responsibility in connection with such use by me and no legal action will ever be brought against Dr. due to his prescribing oral contraceptive agents for me.

Dated:, 19.....

Witness:

.....

.....

Patient

AUTHORIZATION FOR AUTOPSY AND DISPOSITION OF REMAINS

I (We) hereby represent that I am (we are) the (state relationship) of the deceased (name of patient) and that I (we) have the right to control the disposition of the remains of said deceased.

IF THE AUTHORIZATION IS SIGNED BY ONE OTHER THAN THE SURVIVING SPOUSE THE FOLLOWING IS TO BE SUPPLIED.

Other surviving relatives are named below:

Adult children:

.....

.....

Minor children (Under 18 years):

.....

.....

Father

Mother

Adult brothers and sisters

.....

.....

Minor brothers and sisters (under 18 years)

.....

.....

On behalf of myself and the surviving relatives of the deceased (name of patient) including all of those relatives named above, I request and authorize the physicians and surgeons in attendance at the Hospital to perform a complete autopsy on the remains of the deceased (name of patient) and I authorize the removal and retention or use for diagnostic, scientific or therapeutic purposes of such organs, tissues, and parts as such physicians and surgeons deem proper.

This authority is granted subject to the following restrictions:

.....

.....

(If no restrictions, write "None.")

The following special examinations shall be made:

.....

.....

I (We) wish the remains to be released to:

.....

(name of undertaking establishment) (city) (state)

Signed

Signed

Witnesses:

.....

.....

Name of person obtaining Authorization:

.....

Date Time

General Health Services Information

Health services information not listed in this Reference Issue can be obtained by contacting the following:

The Chicago Hospital Council
840 N. Lake Shore Drive
Chicago 60611

Department of Public Health
503 State Office Building
Springfield 62706

Department of Mental Health
State Office Building
Springfield 62706

Department of Children & Family Services
Room 404, New State Office Building
Springfield 62706

Department of Public Aid
618 E. Washington Street
Springfield 62706

Department of Registration & Education
160 N. LaSalle Street
Chicago 60601

Department of Allied Medical Professions & Services
American Medical Association
535 N. Dearborn Street
Chicago 60610

Division of Vocational Rehabilitation
623 E. Adams Street
Springfield 62706

Illinois Hospital Association
840 N. Lake Shore Drive
Chicago 60611

Illinois League for Nursing
2816 N. Ellis
Chicago

Metropolitan Chicago Nursing Home Association
43 E. Ohio Street, Suite 1206
Chicago 60611

Chicago Alcoholism Treatment Center
3026 S. California
Chicago

Illinois Drug Abuse Program
59th & S. Lake Shore Dr.
Chicago 60638

Directories are available for the following:

Child Care Facilities

The Department of Children and Family Services has published a Directory of Licensed Child Care Facilities. This new directory is a quick reference to the services offered by Illinois facilities actively engaged in work with children who are in need of institutional care or other placement services. Included in the directory is basic information about child care institutions, child welfare agencies, maternity centers for minor unwed mothers, and group homes licensed by the Department. The directory is free. Write the Department's Office of Community Relations, 524 S. Second St., Springfield, 62706.

Dentists

American Dental Directory. Available from the American Dental Association, 211 E. Chicago, Chicago, Illinois. Annual. $25. Lists members and nonmembers, military dentists, dental schools, associations linked to ADA, examining boards, health agencies, state dental organizations, etc. For Dentists, lists name, address, birth year, dental school, degree, specialty, etc.

Osteopaths

Yearbook and Directory of Osteopathic Physicians. American Osteopathic Association, 212 East Ohio Street, Chicago. Annual. $25 for first copy, $12.50 each additional copy. Covers both members and nonmembers, colleges, associated osteopathic hospitals. For Osteopaths, lists name, address, birth year, osteopathic school, specialty, etc.

Physicians and Surgeons

AMA Geographic Register of Physicians. AMA, 525 North Dearborn, Chicago. Every 2 years. $90. Latest volume April, 1970. Covers both members and nonmembers, colleges, etc. For Medical Doctors, lists name, address, birth year, type of practice, specialty, medical education, license year, boards passed, society memberships, etc.

Podiatrists

Desk Reference, American Podiatry Association, 3301 16th Street NW, Washington, D.C. Annual. About $25. (Free to advertisers; write "Business office".) Includes alphabetic and geographic listing of podiatrists, affiliated organizations, accredited colleges, therapeutic indices and a catalog of audiovisual, informational and educational materials. For Podiatrists, lists name, address, birth year, podiatric specialty, etc.

Drugstores

Hayes Drugstore Directory. Edward N. Hayes, Publisher, 206 West 4th Street, Santa Ana, California. Annual. $36 if buy regularly; $40 one time basis. Lists retail drugstores, estimating volume and credit rating. A list of wholesale druggists is also included.

Internships and Residencies

Directory of Approved Internships and Residencies, AMA, 525 North Dearborn, Chicago. Published in the Fall of the year. Free.

Nursing Homes

U.S. Guide to Nursing Homes. Published by Grosset & Dunlap, Inc., New York City. Each of 3 volumes covers a geographic section of U.S.; $2.95 per volume. Name and address of home, number of beds, medical services available, recreation and entertainment. (Even a section on how to tell someone they are entering a nursing home without feeling guilty. Perhaps a little too consumerish for some, but very worthwhile for the public relations of nursing homes.)

INDEX TO REFERENCE SECTION

A

Accreditation, Subcommittee on 337
Action Report 352
Administration, Division of 350
Aging, Committee on 343
American Medical Association,
Delegates and Alternates to 325
American Association of Medical Assistants,
Illinois Society 360
Ancillary Organizations 358
Annual Meeting Joint Management Committee 346
Approved Education Programs, Schools 362
Arbitration, Sub Committee on 341
Artificial Kidney Centers
for Acute Poisoning Cases 398
Autopsy 407

B

Benevolence, Committee on Finance and 345
Birth Control Information 407
Blood Labeling 408
Board of Trustees 326
Bylaws 304

C

Chicago Medical Society, Officers 331
Child Welfare, Division of 370
Children and Family Services, Department of 370
Director's office 370
Division of—
Child Welfare 370
Education and Rehabilitation Services 370
Financial Management 371
Visually Handicapped Services 370
Certificate of Need, Committee to Study 347
Certified Laboratory Assistants, Approved Schools of ..362
Clinical Laboratories, Licensed 391
Comb-1 Insurance Form 352
Committee on Committees 344
Committees—
Trustee District 333
(*See Specific Committees*)
Constitution and Bylaws 304
Committee on 343
Index to 315
Continuing Medical Education,
Independent Council on 348
Council of Deans, Liaison Committee to the 337
Councils of the Illinois State Medical Society 335
Organization Chart 335
County Medical Societies, Officers of 327
Cytotechnology, Approved Schools of 362

D

Death, Legal Definition, Committee on 340
Delegates and Alternates
to American Medical Association 325
Disaster Hospital Manual 353
District Committees, Trustee 333
Drug and Therapeutics, Committee on 346

E

Economics and Peer Review, Council on 336
Education Programs, Approved (Schools) 362
Certified Laboratory Assistants 362
Cytotechnology 362
Inhalation Therapy 362
Histological Technician 363
Medical 362
Medical Record Administrators 362
Medical Record Technicians 362
Medical Technology 363
Nuclear Medicine Technology 363
Nursing 364
Associate Degree Programs 364
Bacculaureate Degree Programs 365
Diploma Programs 366
Practical 367
Occupational Therapy 362
Physical Therapy 362
Radiation Therapy Technologist 363
Radiologic Technologist 363
Education and Manpower, Council on 336
Education and Rehabilitation Services, Division of 370
Educational and Scientific Foundation, Committee on 347
Environmental and Community Health, Council on 338
Ethical Relations Committee 344
Ethics, Principles of Medical 299
Executive Committee 344
Eye Health Committee 340

F

Films 352
Finance and Benevolence Committee 345
Food and Drug, Division of 375
Forensic Medicine, Committee on 340
Foundation for Medical Care 361
Free Standing Committees 345

G

General Health Services Information 411
Governmental Affairs,
Council on 339
Division 350
Governmental Health Program Reimbursement 336
Group Disability Program 356
Group Major Medical Expense Plan 356

H

Health Care Delivery, Division of 350
Health Care Priorities, Committee on 347
Health Careers Council of Illinois, Rep. to 348
Health Services Information, General 411
Histological Technician,
Approved Education Programs 363
History of Founding and Expansion of ISMS 300
Hospital Income Plan 356
Hospital Manpower, Committee on 347
Hospital Patient Records 405
Hospital
Packaged Disaster 404
Special Type of Service 390
State Mental Health Facilities 390
House of Delegates, ISMS 326
Ex-officio members of 326

I

Illinois Controlled Substances Act 406
Illinois Foundation for Medical Care 361
Illinois Society, American Association of
Medical Assistants 360
Officers and Advisors 361
Illinois Medical Political Action Committee (IMPAC) 360
Illinois Regional Medical Program
Regional Advisory Group 389
Illinois State Government 369
Department of
Children and Family Services 370
Mental Health 371
Public Aid 373
Public Health 375
Registration and Education 380
Executive Branch 369
Legislative Branch 369
Staff Officers 369
Illinois State Medical Society Organization (History) 300
Illinois State Medical Society Services 348
ISMS/IPS Peer Review Consulting Committee 342
Impartial Medical Testimony 355
Index to the Constitution and Bylaws 315
Inhalation Therapy, Approved Schools of 362
Insurance, Committee on 346
Insurance Form, Comb-1 352
Insurance Programs 355

J

Joint Management Committee, Annual Meeting 346

L

Legal Definition of Death, *Ad hoc* Committee on 340
Liability, Limits on 407
Local Health Departments 376

M

Manpower, Subcommittee on 337
Map of Trustee Districts 332
Marriage License Examination 407
Maternal Welfare, Committee on 338
Medical and Paramedical Education 362
Medical Assistants, American Association of 360
Medical Career Recruitment Programs 353
Medical Ethics, Principles of 303
Medical Examining Committee 380
Medical Legal Council 341
Medical Legal Information 405
Anatomical Gift Act 409
Autopsy 407
Birth Control Information 407
Blood Labeling 408
Hospital Patient Records 405
Illinois Controlled Substances Act 406
Physician-Patient Relationship 405
Smallpox and Rubella 408
Legal Services of ISMS 405
Liability, Limits on 407
Marriage License Examination 407
Negligence Liability of Physicians 405
Unemployment Compensation 408
Medical Practice Act 380
Medical Record Technicians Librarians,
Approved Schools of 362
Medical Record Administrator, Approved School of 362
Medical Students and Physicians In-Training,
Medical Schools in the State of Illinois 362
Advisory Committee to 338
Medical Technology, Approved Schools of 363
Mental Health, Department of 371
Offices of the Director 371
Divisions 371
Regions and Institutions 371
Mental Retardation Services, Division of 372
Non-statutory Boards and Councils 373
Statutory Boards and Councils 372
Mental Health and Addiction, Council on 341
Mental Health Facilities, State 391
Mental Retardation Services, Division of 372
Modern Management of Multiple Births, Film 352
Mutual Fund 356
Multiphasic Testing and Screening 323

N

Nuclear Medicine Technology, Approved School of 363
Nursing,
Programs Approved
Associate Degree 364
Baccalaureate Degree 365
Diploma 366
Practical 367

O

Occupational Therapy, Approved Program of 362
Officers
Chicago Medical Society 331
County Medical Societies 327
Illinois State Medical Society
and Places of Meetings—Since Organization
of Society 301
State of Illinois 369
On the Legislative Scene 352
Oral Contraceptive Forms 353
Organization Chart, ISMS Councils 335

P

Packaged Disaster Hospitals 404
Past Presidents 301
Personal Life Insurance Program 357
Physicians Placement and Student Loan Fund Program 354
Physician-Patient Relationship 405
Poison Control Centers 400
Policy Committee 345
Policy Manual of ISMS 316
Principles of Medical Ethics 303
Professional Liability Program 357
Public Affairs, Committee on 340
Public Aid, Department of 373
Administrative Staff 373
Advisory Committees 374
Regional officers 374
Public Health, Department of 375
Officers of Program Planning 375
Artificial Kidneys 398
for Acute Poisoning Cases
Bureau of
General Administration 375
Branch Office 376
Hospitals
with Special Type of Service 390
State Mental Health Facilities 391

Licensed Clinical Laboratories 391
Local Health Departments 376
Statutory Boards 378
Non-Statutory Boards 379
Packaged Disaster Hospitals 404
Poison Control Centers 400
Renal Dialysis 397
Facilities, Centers and Directors, Approved 397
Units and Directors, Approved 398
Statutory Boards and Commissions 378
Public Relations and Membership Services, Division of 351
Public Relations and Membership Services, Council on 342
Publications Committee 345
Publications and Scientific Services, Division of 351

R

Radiation Therapy Technologist, Approved School for 363
Radiologic Technologist, Approved Education Program For 363
Radio, Television, Public Service Materials 351
Regional Medical Program
Regional Advisory Committee 389
Registration and Education, Department of 380
Medical Examining Committee 380
Medical Practice Act 380
Other Examining Boards 388
Rehabilitation Services, Committee on 343
Renal Dialysis Centers and Units 397
Retirement Investment Program 355
Rubella and Smallpox 408

S

Schools, Approved
Certified Laboratory Assistants 362
Cytotechnology 362
Histological Technician 363
Inhalation Therapy 362
Medical 362
Medical Record Administrators 362
Medical Record Technicians 362
Medical Technology 363
Nuclear Medicine Technology 363
Nursing 364
Occupational Therapy 362
Physical Therapy 362
Radiation Therapy Technologists 363
Radiologic Technologists 363
Scientific Speakers Bureau 353
Services, ISMS 348
Services, Legal 435
Social and Medical Services, Council on 342
Smallpox and Rubella 408
Special Project Committee to Ill. Department of Mental Health 346
Special Publications 352
Staff Organization Chart 349
Student Loan Fund Board 347
Student Visitation Program, Subcommittee on 337
Swanberg Foundation, Rep to 348

T

Tax-Qualified Retirement Program 357
Term Life Insurance Program 357
Trustee District Committees 333
Trustee Map, Board of 332

U

Unemployment Compensation 408

V

Visually Handicapped Service 370
Vocational Rehabilitation, Division of 389

W

Woman's Auxiliary 358
Advisory Committee, to the 345
Chairman of the Committees 359
Directors 359
District Councilors 360
Officers 359

COOK COUNTY
Graduate School of Medicine
CONTINUING EDUCATION COURSES
STARTING DATES—1972

SPECIALTY REVIEW COURSE IN SURGERY, Part I, October 23; Part II, Nov. 27
SPECIALTY REVIEW COURSE IN OB-GYN, October 16
STATE & NATIONAL BOARD REVIEW COURSE, Basic, Nov. 5
STATE & NATIONAL BOARD REVIEW COURSE, Clinical, Nov. 13
PRE & POSTOPERATIVE CARE OF PATIENTS, 4 Days, Nov. 8
SURGERY OF TRAUMA, 4 Days, December 11
SYMPOSIUM ON SHOCK, 2 days, December 15
MANAGEMENT OF COMMON FRACTURES, One Week, Oct. 23
DISEASES OF ESOPHAGUS, STOMACH & DUODENUM, 2½ Days, Nov. 2
ADVANCES IN OBSTETRICS & GYNECOLOGY, One Week, Nov. 13
BASIC OBSTETRICS, One Week, November 27
BASIC GYNECOLOGY, One Week, December 4
INTERMEDIATE CARDIOLOGY, 4½ Days, October 16
FAMILY PRACTICE REVIEW, One Week, October 30
CLINICAL PSYCHIATRY, Four Days, October 31
ADVANCES IN MEDICINE, One Week, November 27
GENERAL PEDIATRICS, One Week, November 27
ACUTE CARDIAC CARE, Three Days, December 5
INHALATION & REGIONAL ANESTHESIA, Request Dates

Information concerning numerous other continuation courses available upon request.

Address:

REGISTRAR, 707 South Wood Street,
Chicago, Illinois 60612

E & M MEDICAL LABORATORIES, INC.

Near South Side
2600 S. Michigan Ave., Suite 312
Chicago, Illinois 60616

Complete Laboratory Services
including PAP Smears
Computer Processed EKG's
and V.D. Tests

EARL N. CALDWELL, M.D.,
PATHOLOGIST, DIRECTOR
(312) 842-1302



Prescribe
the discoverer's brand
Totacillin®*
(ampicillin trihydrate)

*capsules equivalent to 250 mg. and 500 mg. ampicillin, for oral suspension equivalent to 125 mg./5 cc. and 250 mg./5 cc. ampicillin.

BMP

Beecham-Massengill Pharmaceuticals
Division of Beecham Inc. Bristol, Tennessee 37620

Skin Saver



Alpha-Keri®

therapeutic bath oil

locks in moisture

relieves dry, itchy skin with the first bath or shower.

See PDR. Supplied: 8 and 16 fl. oz. bottles; 5 oz. aerosols.

WESTWOOD PHARMACEUTICALS INC. Buffalo, New York 14213

Send samples of Alpha-Keri bath oil.

DR. _____

ADDRESS _____

CITY STATE ZIP 7

what goes on

a guide to continuing education

October 20-22—Cook County Department of Family Practice, Abraham School of Medicine (University of Illinois) Department of Family Practice, Pfizer Pharmaceuticals.

Symposium on Medical Insights on Birth Death and Some Problems In Between

Contact: Department of Family Practice Cook County (312) 633-8588.
Pheasant Run, St. Charles, IL

October 23-26—The American College of Chest Physicians

38th Annual Scientific Assembly

The four-day educational program will feature workshops, symposia, guest lectures, fireside conferences, tutorial sessions and the presentation of 86 scientific papers. A day of clinic visits to 11 hospitals and teaching centers in Denver has been scheduled for the opening day of the scientific assembly.

In addition, there will be a one-day national seminar for nurses and inhalation therapists on modern methods of managing patients with critical cardiopulmonary problems, and a one-day workshop for physician-authors on scientific writing.

Contact: American College of Chest Physicians, 112 E. Chestnut St., Chicago, IL 60611, 312/787/4933

October 21-26—American Congress on Rehabilitation Medicine

50th Annual Session

Contact: Thomas P. Anderson, M.D., Department of PM & R, 860 Mayo

University of Minnesota Hospitals, Minneapolis

October 25—Adolf Gundersen Medical Foundation and Wisconsin Heart Association

The Seventh Annual Cardiovascular Symposium "Congestive Heart Failure."

This one day program will begin at 9 a.m. with talks by five prominent speakers. An afternoon panel discussion follows investigating the treatment of classic cases of congestive heart failure.

Contact: Mrs. Jane Christensen (608) 785-2400

University of Wisconsin, La Crosse, WI

October 25-28—American College of Surgeons

Twelfth Annual Course on Emergency Aid and Transportation of the Critically Ill and Injured

This Course is for the further training of those who have completed an advanced first aid course and is aimed primarily at the laymen who arrive first at the scene of an accident—such as ambulance drivers, firemen, policemen, emergency squads, safety patrols, safety engineers, public health and civil defense personnel. It is unique in that it is presented by doctors for the education of laymen, with the idea that they will return to their local communities prepared to instruct their fellow public servants.

More than 40 Chicagoland orthopaedic surgeons and general surgeons and 20 other physicians, specialists and City of Chicago fire and police department experts, acting as teachers, will give lectures and demonstrations. Along with other areas of emergency aid, the instruction will cover extrication from cars and from electricity, resuscitation, water rescue, poisoning, fractures, chest injuries, recognition of diabetes, heart attack, strokes and the unconscious patient, transportation of contagious patients, control of the unruly, and safe driving of ambulances.

Contact: James F. Krutz, M.D., Secretary, 11255 West 74th Street, La Grange, IL 60525

Chicago Fire Academy, 558 DeKoven Street, Chicago, IL

October 26-27—University of Iowa

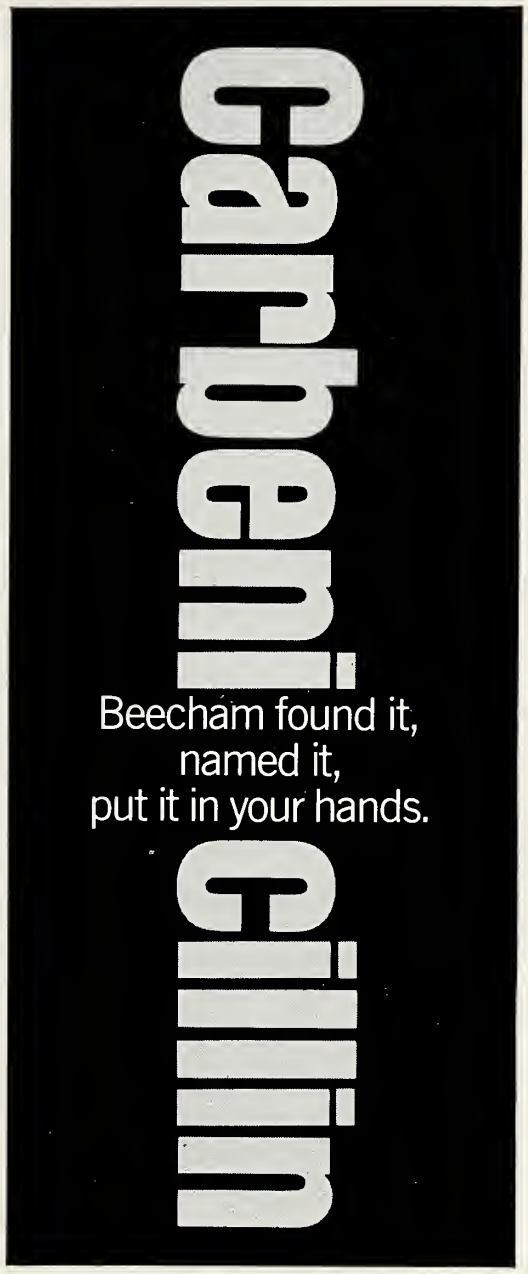
Third Annual Meeting on Antibiotics and Infection

There will be 30 speakers from the University of Iowa plus five guest speakers: Dr. Elisha Atkins of Yale University Medical School; Dr. King K. Holmes of the USPHS in Seattle, Washington; Dr. Calvin M. Kunin of the University of Wisconsin; Dr. William R. McCabe of Boston University; and Dr. David H. Smith of Harvard Medical School.

Contact: Iran M. Smith, M.D., Department of Internal Medicine, University Hospitals, Iowa City, IA 62240

University of Iowa, Iowa City, Iowa

(Continued on page 429)



Prescribe
the discoverer's brand
Pyopen®*
(disodium carbenicillin)

*vials for injection equivalent to 1 gm. and 5 gm. of carbenicillin.

BMP

Beecham-Massengill Pharmaceuticals
Division of Beecham Inc. Bristol, Tennessee 37620



new pharmaceutical specialties

by paul dehaen

For detailed information regarding indications, dosage, contraindications and adverse reactions; refer to the manufacturer's package insert or brochure.

Single Chemicals—Drugs not previously known, including new salts.
Duplicate Single Products—Drugs marketed by more than one manufacturer.
Combination Products—Drugs consisting of two or more active ingredients.
New Dosage Forms—Of a previously introduced product.

The following new drugs have been marketed:

SINGLE CHEMICALS

TRICLOS
Sedatives & Hypnotics-Nonbarbiturate ℞
Manufacturer: Lakeside
Nonproprietary Name: Triclofos sodium
Indications: Insomnia
Contraindications: Marked renal or hepatic impairment and allergy to chloral hydrate or triclofos sodium.
Warning: May be habit-forming
Precautions: Use with cautions in patients with cardiac arrythmias and severe cardiac disease. Safety in pregnancy has not been established. Use in children under 12 not recommended.
Dosage: 1500 mg., 15-30 mins. before sleep
Supplied: Tablets, 750 mg.

DUPLICATE SINGLE PRODUCTS

DERMACORT Corticoids ℞
Manufacturer: Rowell
Nonproprietary Name: Hydrocortisone
Indications: Inflammatory skin disorders amenable to topical corticosteroid therapy.
Contraindications: Tuberculosis of skin, herpes simplex, vaccinia, varicella. Fungal & Bacterial skin infections, unless treated concomitantly with antimicrobials.
Precautions: Prolonged or copious use may produce adverse systemic corticosteroid effects.
Dosage: Apply liberally to affected area 2-4 times daily.
Supplied: Cream 1%.

ORASONE Corticoids ℞
Manufacturer: Rowell
Nonproprietary Name: Prednisone
Indications: Conditions known to respond to corticosteroid therapy.
Contraindications: Systemic fungal infections
Precautions: Pts. should not be vaccinated against smallpox and other conditions while on corticosteroids. Use during pregnancy requires that benefits be weighed against hazards to fetus. Caution in pts. with ocular herpes simplex.
Dosage: Individualized according to severity of condition and response of pt.
Supplied: Tablets, 1 mg., 5 mg., 10 mg., 20 mg.

PENSYN Penicillin Derivative ℞
Manufacturer: Upjohn
Nonproprietary Name: Ampicillin Trihydrate
Cautions: Hypersensitivity to Penicillin
Precautions: Those usual with antibiotics
Dosage: Patients weighing more than 20 kg.: 250 mg. every 6 hours.
Patients weighing less than 20 kg.: 50 mg./kg./day in equally divided doses at 6 to 8 hour intervals.
Supplied: Capsules 250 and 500 mg.

RO-AMPEN Penicillin & Deriv. ℞
Manufacturer: Rowell
Nonproprietary Name: Ampicillin Trihydrate
Indications: Infections due to susceptible organisms.
Contraindications: Hypersensitivity to any penicillin
Precautions: Allergic individuals. Safety for use during pregnancy has not been established.
Dosage: Depends on type and severity of infection.
Adults: 250-500 mg. 4 times daily
Children: 50-100 mg./kg./day (in equally divided and spaced doses 3-4 times daily).
Supplied: Capsules, 250 and 500 mg.

RO-CILLIN VK Penicillin & Deriv. ℞
Manufacturer: Rowell
Nonproprietary Name: Potassium Phenoxymethyl Penicillin
Indications: Mild to moderate infections due to susceptible organisms.
Contraindications: Hypersensitivity to any penicillin.
Dosage: Depends on type & severity of infection
Supplied: Tablets, 250 and 500 mg.

RO-CYCLINE 250
RO-CYCLINE 500 Antibiotics-B&M Spectrum ℞
Manufacturer: Rowell
Nonproprietary Name: Tetracycline HCl
Indications: Infections due to susceptible organisms
Contraindications: Hypersensitivity to tetracyclines
Precautions: Evidence of embrotoxicity and fetal toxicity
Dosage: Usual dosage:
Adults: 1-2 gms. daily in divided doses
Children: 10-20 mg./lb. divided in 4 equal doses
Supplied: Capsules, 250 and 500 mg.

NEW DOSAGE FORMS

PENSYN Penicillin Derivative ℞
Manufacturer: Upjohn
Nonproprietary Name: Ampicillin Trihydrate
Cautions: Hypersensitivity to Penicillin
Precautions: Those usual with antibiotics
Dosage: Patients weighing more than 20 kg.: 250 mg. every 6 hours.
Patients weighing less than 20 kg.: 50 mg./kg./day in equally divided doses at 6 to 8 hour intervals.
Supplied: Oral Suspension, 125 or 250 mg./cc.

RO-CILLIN VK Penicillin & Deriv. ℞
Manufacturer: Rowell
Nonproprietary Name: Potassium Phenoxymethyl Penicillin
Indications: Mild to moderate infections due to susceptible organisms.
Contraindications: Hypersensitivity to any penicillin
Dosage: Depends on type and severity of infection
Supplied: Solution: 125 mg/5 cc. and 250 mg./5 cc.

TRICLOS

Sedatives & Hypnotics-Nonbarbiturate ℞
Manufacturer: Lakeside
Nonproprietary Name: Triclofos sodium
Indications: Insomnia
Contraindications: Marked renal or hepatic impairment and allergy to chloral hydrate or triclofos sodium.
Warning: May be habit-forming
Precautions: Use with caution in pts. with cardiac arrythmias and severe cardiac disease. Safety in pregnancy has not been established. Use in children under 12 not recommended.
Dosage: 15 cc. liquid, 15-30 mins. before retiring
Supplied: Liquid, 1.5 gm./15 cc.

Leadership

Conference

Sunday, October 29, 1972

Regency Hyatt House, Chicago



Prescribe
the discoverer's brand
Bactocill®*
(sodium oxacillin)

*capsules equivalent to 250 mg. and 500 mg. oxacillin and vials for injection equivalent to 500 mg. and 1 gm. oxacillin.

BMP
Beecham-Massengill Pharmaceuticals
Division of Beecham Inc. Bristol, Tennessee 37620

★

Specialized Service

IN

PROFESSIONAL LIABILITY INSURANCE

is a high mark of distinction

THE

MEDICAL PROTECTIVE COMPANY

FORT WAYNE, INDIANA

Professional Protection Exclusively since 1899

CHICAGO AREA OFFICE: T. J. Pandak, J. C. Kunches, and L. R. Gannon, Representatives
T. J. Hoehn, Consultant
815 Commerce Drive, Suite 102, Oak Brook, Illinois 60521 (312) 325-7314
SPRINGFIELD OFFICE: W. J. Nattermann, Representative
426½ South Fifth Street, Springfield 62701 (217) 544-2251

Twenty Seven Clinics for Crippled Children

Twenty seven clinics for Illinois' physically handicapped children have been scheduled for November by the University of Illinois, Division of Services for Crippled Children. The Division will count twenty-two general clinics providing diagnostic orthopedic, pediatric, speech and hearing examination along with medical social, and nursing services. There will be four special clinics for children with cardiac conditions, and one for children with cerebral palsy. Any private physician may refer to or bring to a convenient clinic any child or children for whom he may want examination or consultative services. The schedule for the clinics in November are:

Nov. 1 Hinsdale—Hinsdale Sanitarium
Nov. 2 Sterling—Sterling Community Hospital
Nov. 2 Effingham—St. Anthony Memorial Hospital
Nov. 2 Pittsfield—Illini Hospital
Nov. 2 West Frankfort—Union Hospital
Nov. 7 Belleville—St. Elizabeth's Hospital
Nov. 7 Fairfield—Fairfield Memorial Hospital
Nov. 8 Joliet—St. Joseph's Hospital
Nov. 8 Champaign-Urbana—McKinley Hospital
Nov. 9 Springfield—St. John's Hospital
Nov. 9 Macomb—McDonough District Hospital
Nov. 10 Chicago Heights Cardiac—St. James Hospital
Nov. 14 Peoria—St. Francis Hospital
Nov. 14 E. St. Louis—Christian Welfare Hospital
Nov. 15 Evergreen Park—Little Company ot Mary Hospital
Nov. 15 Rockford—St. Anthony's Hospital
Nov. 15 Centralia—St. Mary's Hospital
Nov. 16 Elmhurst Cardiac—Memorial Hospital of DuPage County
Nov. 16 Decatur—Decatur Memorial Hospital
Nov. 16 DuQuoin—First Methodist Church
Nov. 17 Chicago Heights Cardiac — St. James Hospital
Nov. 21 Rock Island Area General—Moline Public Hospital
Nov. 22 Elgin—Sherman Hospital
Nov. 22 Springfield Pediatric Neurological — Diocesan Center
Nov. 27 Peoria Cardiac—St. Francis Hospital
Nov. 28 Peoria—St. Francis Hospital
Nov. 28 Alton—Alton Memorial Hospital

Doctor's News

LEADERSHIP CONFERENCE, OCT. 29—Physicians are urged to attend the annual ISMS Leadership Conference, Sunday, October 29, at the Regency Hyatt House, Chicago. The conference will begin at 9:25 a.m. with the welcome given by Jacob E. Reisch, M.D., chairman. Malpractice and arbitration will be discussed in depth by spokesmen from the legal and medical professions. For more information and registration, contact ISMS Headquarters, 360 N. Michigan Ave., Chicago 60601.

GOVERNMENTAL AFFAIRS SPEAKERS BUREAU—Alfred J. Faber, M.D., chairman, Governmental Affairs Council and George T. Wilkins, M.D., chairman, Public Affairs Committee, are organizing a speakers bureau to discuss legislative, governmental, and political developments which affect the practice of medicine in Illinois.

"If a county officer desires to have a speaker to discuss developments, he should first contact the ISMS Governmental Affairs Division, specifying the date, time, estimated attendance and location of the county meeting," says Dr. Faber.

Speakers already available include Dr. Faber; Dr. Wilkins; J. Bernie Robinson, Director to the Governmental Affairs Division; Larry Booth, Legislative Assistant; Mrs. Allan (Pam) Taylor, chairman of the Woman's Auxiliary Governmental Affairs Representative; and Mrs. Harlan (Pat) Failor, Chairman, Woman's Auxiliary Public Affairs Committee.

NEED FOR STATE MEDICAL DISCIPLINARY BOARD—In testimony before the Illinois Health Care Licensure Commission, ISMS recommended a special state medical disciplinary board to investigate physicians suspected of incompetence or serious misconduct. "A tremendous increase in applications for licensure has made it difficult for the Illinois Department of Registration and Education to enforce the Medical Practice Act," said Dr. Frank J. Jirka, Jr., president of ISMS. "A disciplinary board composed of physicians and authorized to suspend or revoke licenses is the most effective method of censuring incompetence," remarks Dr. Jirka. This medical disciplinary board is constitutional in Illinois and requires only enabling legislation.

HEART ASSOCIATION RECEIVES GRANTS—A total of $505,207 in research grants have been awarded to the Chicago and Illinois Heart Associations. The allocated funds will be dispensed to 48 scientists representing seven Illinois universities and five area hospitals.

PHYSICIANS IN THE NEWS—Officers of the Chicago Society of Allergy are: Charles L. Sewarts, M.D., president: Milda Budrys, M.D., president-elect; and Martin J. Kaplan, M.D., secretary-treasurer.

Raoul Fresco, M.D., associate professor of pathology at the University of Health Sciences/The Chicago Medical School, received the Board of Trustees Research Award at the commencement exercises June 8. Recognized as an authority on ultrastructural investigation, Dr. Fresco has earned a reputation also as an authority on the use of the electron microscope.

HEW AWARDS GRANT FOR ILLINOIS HOSPITAL CREDENTIALING PROJECT—Rush/Presbyterian-St. Luke's Medical Center, Chicago, has been granted $96,000 finance phase I, the development of a demonstration project in Illinois of "Credentialing Health Personnel by Licensed Hospitals". . . a supplement or alternative of existing forms of licensing, accrediting or registering of health personnel (in) dependent roles. The objective is to learn whether quality

of hospital patient care can be better assured when each hospital annually reviews and credentials its own allied health personnel. Phase II, the actual field study and evaluation would be undertaken a year from now with a second grant contingent upon development of an acceptable plan in phase I. Project sponsors are the board of trustees of ISMS, Illinois Nurses Association and Illinois Hospital Association.

DOCTOR STEIN LEADS NEW COUNCIL—Leonard S. Stein, Ph.D., an educator and political scientist, has been named executive director of the Illinois Council on Continuing Medical Education. Dr. Stein previously served as dean of continuing education and summer sessions at Adelphi University, Garden City, N.Y. ISMS created this new council to help keep physicians up to date on developments in medicine.

Some of the purposes of the Council are to: 1) make available to all Illinois physicians continuing medical education programs that will improve patient care; 2) study and coordinate existing education programs and eliminate wasteful duplication of effort; 3) study and encourage development of new educational methods, techniques and systems; 4) ascertain educational needs of physicians locally through self-testing and other motivation devices; 5) seek out potential providers of educational programs and to serve as liasion between producers and consumers.

Serving on the board of directors of the Council, an independent corporation at 360 N. Michigan Ave., are nine members appointed by ISMS and representatives from each of the state's eight medical schools. Dr. J. Ernest Breed, Chicago, former ISMS president is chairman pro tem of the Council. Permanent officers will be installed in January, 1973.

TRIBUTE TO FRANK J. JIRKA, JR.—Frank J. Jirka, M.D., president of the Illinois State Medical Society, recently received high tribute for his professional committment and for his many contributions and efforts on behalf of medical welfare in Illinois. Representative R. J. Welsh, Oak Park, offered House Resolution No. 560 to the State of Illinois Seventy-seventh General Assembly, House of Representatives, which honored Dr. Jirka, a urologist and resident of River Forest.



Frank J. Jirka, Jr., M.D.

The resolution noted Dr. Jirka's many professional affiliations and attainments, including his leadership role in ISMS. Amidst his busy medical practice, Dr. Jirka devotes time to many worthy civic and social causes. He is a member of the President's Committee on Employment of the Handicapped, National Rehabiliation Association, and the Illinois Commission on Nursing.

Recipient of the Silver Star and Purple Heart, Dr. Jirka's courageous actions as a Navy frogman during World War II caused him to lose both legs; but he didn't lose his ambition to pursue the medical field and to enjoy life. He has great zest for outdoor sports as a hunter and fisherman.

Dr. Jirka strongly feel the great responsibility of his profession. Unselfishly he does thing for people in concern for their welfare.

Congratulations to Frank J. Jirka are in order!

What Goes On

(Continued from page 419)

November 3—Illinois State Medical Society, Illinois Nutrition Committee, Illinois Heart Association and the Illinois Department of Public Health.

15th Annual Nutrition Conference

The Conference, which will begin with registration at 10:00 a.m., is open to physicians, dietitans, nutritionists and other professionals and students in allied health fields from Illinois and adjacent states. Featured luncheon speaker will be Dr. John F. Mueller, chairman of the Committee on Nutrition of the American Heart Association, who will discuss diet and the heart.

Among other subjects to be covered during the Conference will be malnutrition and learning, and nutrition and diabetes.

Contact: Mr. Mike Wild, Illinois State Medical Society, 360 N. Michigan Ave. 60601 (ST 2 1654)

Southern Illinois University, Carbondale

November 6-8—American Academy of Orthopaedic Surgeons

Post-graduate course—"The Modern Approach to Prosthetics

This course is offered to orthopaedic surgeons and other physicians concerned with rehabilitation of the amputee and patients in need of orthotic appliances. It is offered also to nurses, orthotists, prosthetists, and physical and occupational therapists.

Discussed will be selection of the proper level of amputation, preprosthetic treatment, and prosthesis prescription. Requirements for orthoses will be approached from the biomechanical standpoint. Among topics are spine orthoses, electric and self-propelled wheelchairs, the Milwaukee Brace, crutches, canes, and walkers.

Contact: Robert G. Thompson, M.D., 737 North Michigan Avenue, Chicago IL 60611

The Sheraton-Chicago Hotel, Chicago, IL.

November 8-10—American College of Emergency Physicians

The Fourth Annual Scientific Assembly

Presented will be the original scientific papers featured speakers and scientific exhibits.

Contact: Richard T. Johnson, Managing Editor, American College of Emergency Physicians 241 East Saginaw, East Lansing, Michigan 48823

November 9-11—Chicago Medical Society

The 1972 Post-graduate Course in Internal Medicine

This year's course is being offered in Internal Medicine and will feature a distinguished faculty drawn from each of the six Chicago area medical schools.

The format is expected to follow the lines successfully introduced at the last postgraduate course in which each session will feature a main discourse on a given phase of internal medicine delivered by a faculty member, after which participants will hold roundtable discussions presided over by members of the faculty. Participants will have a chance to analyze and review salient points of the discussion at the roundtables.

Contact: T. J. Sacks—922-0417

Sheraton-Chicago Hotel, Illinois

November 10—The Institute of Medicine of Chicago

1792 Workshop "Ambulatory Care"

This will be an open forum on four critical problems now facing medicine and its practitioners.

Fee: $15.00 for Institute Fellows, $20.00 for non-members; luncheon guests $6.00 each.

Contact: The Institute of Medicine of Chicago

Ambassador West Hotel, Chicago, IL

November 10-11—Medical College of Wisconsin

Third Annual Joint Symposium on Kidney Diseases

Discussions will center on genetic aspects of renal disease, drugs and the kidney and topics in urinary tract surgery. Speakers include faculty members from the Medical College of Wisconsin; University of Wisconsin; Stanford University, School of Medicine; Pennsylvania University, School of Medicine; University of Minnesota; and the Mayo Graduate School of Medicine.

Fee: $35.00

Contact: Medical College of Medicine, Toran, Marphetia 561 North 15th Street Milwaukee, WI 53233

Sheraton-Schoeber Hotel, Milwaukee

November 11-12—American Society of Anesthesiologists

ASA Workshop on Acid Base Balance

Contact: ASA, 515 Busse Highway, Park Ridge, IL 60068

Marriott Motor Hotel, Chicago, IL

November 12-16—International College of Surgeons

5th Western Hemisphere Congress

Pre-registration is suggested.

Contact: 5th Western Hemisphere Congress, 136 North Brighton Street, Burbank, CA 91506

November 13-16—Interstate Post-graduate Medical Association

Scientific Assembly

Fee: $25.00

Contact: Interstate Postgraduate Medical Association, P.O. Box 5445, Madison, WI 53705

Washington-Hilton Hotel

(Continued on page 435)



practice management

By R. Allen Diener, Senior Consultant
Professional Business Management, The 400 Center
400 County Line Road, Deerfield, Il. 60016

Tax Shelters

At this time of year many doctors begin wondering how they can cut their income tax burden and much interest is thus generated in "tax shelters."

"Tax shelters" are basically of two natures—those which reduce current tax bills by putting off the obligation until a later year; and those which reduce or eliminate a tax liability altogether. Some shelters are a combination of these two.

The self-employed retirement or "Keogh" plan, the corporate pension, and profit sharing plans are excellent methods of deferring tax obligations from the present to a future (and presumably lower) taxable year. Investment in cattle-raising ventures is another (though usually speculative) deferral-type of tax shelter.

Those shelters which reduce or eliminate current liability for taxes (and also may defer some tax to later years) usually do so through depreciation (and/or) depletion deductions. These deductions reduce taxable income on your personal tax return. Investments of this type usually, are packaged in the form of a "limited partnership" or "syndication" which enables doctors to invest amounts of $5,000, $10,000, etc. Liability is limited to your investment and management "headaches" are left to the managing agent or "general" partner.

We advise clients to stay away from "living" syndications like orange groves, oyster farms, nut groves, vineyards, etc. These investments tend to be high risk and of dubious long-term profitability.

Oil and other mineral syndications usually provide both depreciation and depletion deductions, often amounting to as much as 65% to 90% of the investment in the first year. Thus a $10,000 investment in a drilling venture could conceivably save $4,750 income tax for the doctor in a 50% tax bracket. The next year he might write off another $1,000 (saving $500.00 tax) and, if the project is successful, he may have income from the sale of oil in the third and subsequent years, decreased by a depletion allowance of 22% of gross income from the wells. The long-term value of oil and other mineral syndications is tied to the success of the exploration venture and thus is usually classed as a "speculative" investment by investment analysts.

Real estate syndications, though not usually offering the high first year tax write-offs that oil may, are the investment of choice, by an ever increasing number of physicians. Real estate is tangible; its value can be readily appraised; the property often remains valuable even in the face of poor management. Tax deductions arise from depreciation, real estate taxes, and mortgage interest, as well as from current operating expenses.

A $10,000 investment in improved real estate may give you a 25% to 75% first year write-off for tax purposes, return you 7% to 15% cash flow annually, and conceivably grow at a 4% annual rate. When the property is sold 7 to 10 years hence, profits on the sale will be taxed at the long-term capital gain tax rate, rather than at ordinary income tax levels. Marshall Field once said, "Real estate is not a way to make money, it is the *only* way!"

Before making that hasty decision to save income taxes by responding to that colorful brochure touting Florida orange groves or California beef cattle, review some of the above with your tax advisor or management consultant. Invest only when the offering will "stand on its own feet," regardless of tax advantages. ◄

the view box

Leon Love, M.D./Chairman/Department of Radiology
Loyola University Stritch School of Medicine

This 32 year old female had a previous history of removal of a carcinoma of the parotid four years prior to admission. At the current time she complained of joint pains. Physical examination revealed the surfaces of the long bones to be painful to touch. (Figures 1, 2, 3)

What's your diagnosis? (Answer on page 435)



Figure 1



Figure 2



Figure 3

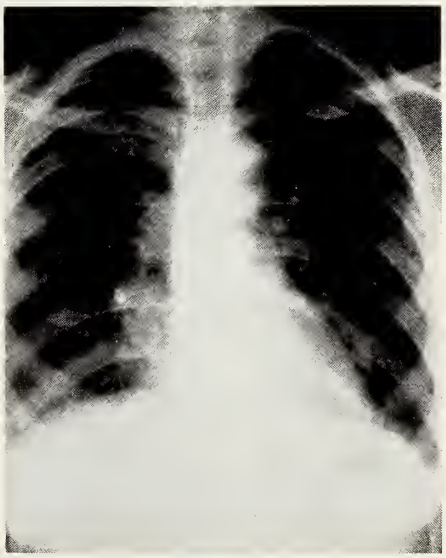
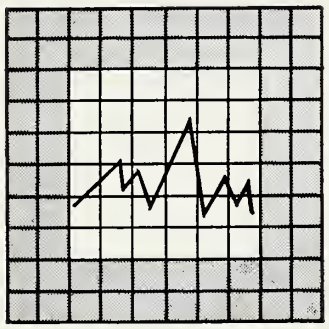
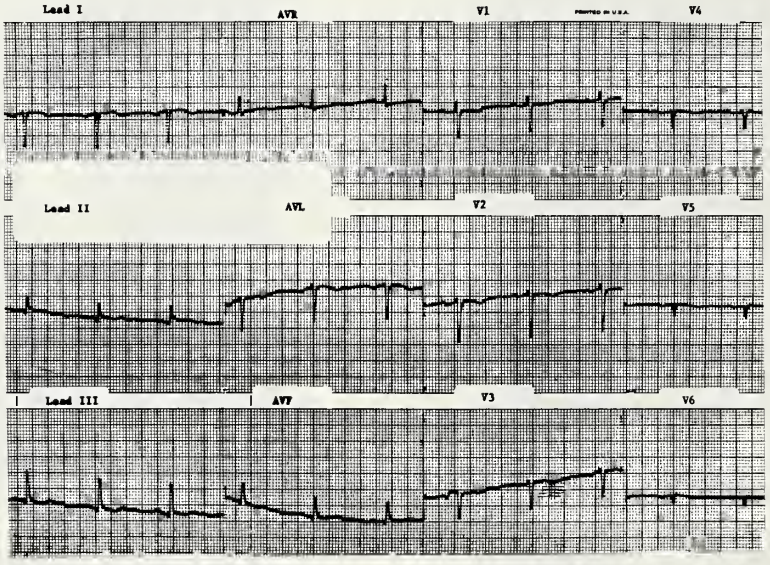


Figure 4



ekg of the month

John R. Tobin, Jr., M.D., M.S., Rimgaudas Nemickas, M.D., Patrick Scanlon, M.D., John F. Moran, M.D. and James V. Talano, M.D./Section of Cardiology, Loyola University Stritch School of Medicine



A sixty-one year old lady presented with a history of decreasing vision in her left eye for the past year. A diagnosis of lenticular cataract was made. Surgery for cataract removal was scheduled and a routine electrocardiogram and chest X-ray were obtained.

1. The electrocardiogram above:

A. Was taken with the right and left arm leads reversed.

B. Is compatible with mirror-image dextrocardia.

C. Shows an extensive old anterolateral wall myocardial infarction.

D. Is compatible with the right ventricular hypertrophy seen in chronic obstructive pulmonary disease.

2. Which of the following are true?

A. The chest X-ray showed situs inversus.

B. Mirror-image dextrocardia means a right sided heart with situs inversus of the viscera and atria.

C. Associated congenital heart defects are common and play a large part in the prognosis.

(Answers on page 435)



editorials

Are Medical Unions Inevitable?

The idea that physicians should form a tough union to protect themselves now is being discussed quite widely. Medical unions do exist and we are not referring to the unfounded statements by many laymen that the American Medical Association is a strong union. Eight unions and guilds have already been organized representing 15,000 physicians. Thirty Nevada physicians formed the Nevada Physicians Union, Local 676 of the Service Employees International Union, AFL-CIO. In California, the Union of American Physicians was launched with 600 participants. It now has 1,000 members. Texas has the American Physicians' Union.

Many physicians are self employed or incorporated, but they alone do not set fees. Government and insurance carriers play an important role. Legally, physician unions can negotiate their own fees so long as the organizations are not engaged in price fixing.

Full-time practicing and teaching physicians are in the best position for unionization. Those in solo or corporate practice are interested because of their dealings with third party groups—government, hospital, and insurance.

Still others hope that a union will help them as a group to retain their professionalism and dignity. And the push for unionization is not coming from the labor people. An aide of George Meany said that affiliation is not appropriate now because M.D.'s are employers. "In 5 to 10 years when most of you are employees, we'll be very interested in you."

In this country, unions carry a bigger clout than associations. As a warning, may I suggest that medical unions be run by a physician. Avoid belonging to a union made up of physicians, interns, nurses, technicians, cleaning women, window washers, and kitchen aids. A big union has more power, but the nonphysician majority will have the voting power and take over control.

American physicians will never forget the mistake that the British Medical Association made when they turned their back on unions leaving their destiny to the politicians. Medical associations no longer can afford the luxury of complacency. Dr. Mark R. Johnson, editor of the journal of Oklahoma State Medical Association believes we should go on strike—not against our patients—but against "participating in a plan for our own enslavement, promoting the abandonment of our own ethics, and conspiring in a treason against our own profession."

He suggests that we (1) refuse to participate in any peer review program that is compulsory, comprised of nonphysicians or supervised by politicians or their appointees; (2) resign from utilization review committees in all our hospitals and see whether anyone else would volunteer to assume these responsibilities and liabilities (3) advise our patients and their fiscal agents that we will no longer serve as intermediaries, that we will deal only with patients; and (4) that we stop filling out insurance company questionnaires and affirm our authority in all dealings with hospitals, extended care facilities, and nursing homes.

He omits refusing to fill out all birth and death certificates and the millions of hours devoted to hospital work that have nothing to do with patient care. He believes a strike will create terror in the hearts of bureaucrats and generate esprit among physicians everywhere. It will leave us time to concentrate on the care of our patients. And his recommendations end with:

"To hell with the blindfold. Strike."

T. R. Van Dellen, M.D.

References

30 Nevada Physicians Organize AFL-CIO Union. "Internal Medicine News" (May 1) 1972, pgs. 1, 34 & 35.

(Unions) "Medical News Report." (July 17) 1972, pg. 1.

(Nationwide Strike of MDs) "Medical News Report" (Aug. 14) 1972.

Ibdem (June 5) 1972, pg. 3 re: Geo. Meany aid reply.

AMA Chief Says MD Unionism Violates Medical Ethics. "Skin and Allergy News" (Aug.) 1972, pg. 40.

Anthony Bottone.: Doctors' Unions: They're Here Right Now. "Medical Opinion" (July) 1972, pgs. 14-19.

Physicians' Attitude Survey. "Medical Opinion" (July) 1972, pgs. 23-24.

The U. S. Government does not pay for this advertisement.
It is presented as a public service in cooperation with The
Department of the Treasury and The Advertising Council.

Invest in the United States of America.

Almost 200 years at the same location.

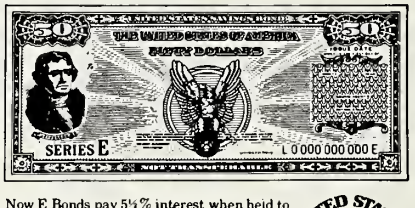
The U.S.A.'s been in business a long time. So it's pretty solid.

And that's what makes U.S. Savings Bonds such a reliable and sure way to build a nest egg.

Bonds are completely safe, too. Lost, stolen, burned. It makes no difference. Your Bonds will be replaced if anything happens to them.

Why not turn a few green dollars into some blue chip U.S. Savings Bonds? Join the Payroll Savings Plan where you work or buy Bonds at your bank.

U.S. Savings Bonds. They're a solid way to save.



Now E Bonds pay 5½% interest when held to maturity of 5 years, 10 months (4% the first year). Bonds are replaced if lost, stolen, or destroyed. When needed they can be cashed at your bank. Interest is not subject to state or local income taxes, and federal tax may be deferred until redemption.

UNITED STATES SAVINGS BONDS

Take stock in America.

Bonds are a safe way to save.

What Goes On

(Continued from page 429)

November 17—The Diabetes Association of Greater Chicago

15th Annual Symposium on Diabetes Mellitus

The theme of the Symposium will be "Diabetic Complications—Recent Developments."

Faculty members will hold a series of workshops in smaller groups with the attending audience bringing their special problems or questions for discussion. These group discussions will continue until the luncheon, which is available by subscription.

Fee: For members, medical students, resident house staff members, and nurses it is free. For non-members it is $10.00.

Contact: Diabetes Association of Greater Chicago, 620 N. Michigan Ave., Chicago, IL 60611.

Holiday Inn, One South Halsted Street, Chicago

EKG of the Month

(Continued from page 432)

Answers:

1B, 2 all. Once the ECG leads are found to be correctly applied, this is a right-sided heart. The P wave is negative in leads I and avL, and it is positive in leads avR and avF. The P wave also progresses from positive to negative across the precordial leads V_1 to V_6. This speaks for atrial inversion and goes along with situs inversus of the abdominal viscera. There is no evidence for ventricular hypertrophy and was no clinical evidence for any associated cardiac anomalies. In all likelihood this patient survived to adulthood because of the absence of any additional cardiac anomalies. She underwent an uneventful cataract removal.

Viewbox

(Continued from page 431)

DIAGNOSIS: *Pulmonary Hypertrophic Osteoarthropathy*—Figure 4. The film of the hands shows a soft tissue swelling over the terminal phalanges with cortical thickening noted in the metacarpals. Similar changes are noted along the shaft of the tibia and fibula as well as the radius and ulna. The chest film revealed multiple metastatic nodules in both lung fields. (Figure 4) Various types of periosteal change have been seen such as (1) a laminated type, (2) true cortical thickening such as our case shows, with no separating radiolucent line present in this type, and (3) the radiolucent line is easily apparent between the layers of cortex. The changes are seen along the diaphysis of the long bones but the metaphyseal portions are spared. Clinically the first manifestation of carcinoma of the lung may be clubbed fingers with the carcinoma demonstrated at that time. Pulmonary Hypertrophic osteoarthropathy is associated with many pleural and pulmonary conditions which can be inflammatory or neoplastic in character.

World smallpox cases rise 38%

The number of smallpox cases in the world has gone up 38% in the first 7½ months of this year.

The World Health Organization recorded 47,872 cases, compared to 34,697 for the same period in 1971.

Cases of smallpox were reported by 18 countries, 10 of which had importations and are otherwise considered to be smallpox free. In 1971, only 16 countries reported smallpox cases.

WHO attributed the increase in smallpox to improved reporting and surveillance in the eight countries where the disease is endemic.

Illinois State Medical Society
Educational and Scientific Foundation

Established by the Illinois State Medical Society for educational and scientific purposes, this foundation has supported numerous activities for the improvement of the practice of medicine.

Contributions made to the Foundation are deductible in accordance with the Internal Revenue Code.

Bequests, legacies, devises, transfers or gifts to the Foundation are deductible for Federal estate and gift tax purposes.

The Foundation is an ideal recipient of gifts made in memory of deceased friends; memorial funds may be established within the Foundation to honor individuals. Funds may be designated for specific purposes.

Your support of this is encouraged.

Obituaries

*Bohning, Anne Lizetta, Chicago, died May 14, at the age of 80. She was on the faculty of the University of Illinois College of Medicine.

Chapman, Leonard, Chicago, died at the age of 67 on August 12.

*Comess, Oscar Harold, Chicago, died April 30 at the age of 61.

**Gehl, William H., died June 25, at the age of 79. He was on the staffs of Columbus, Augustana and Illinois Masonic Hospitals, and was a physician for more than 50 years.

*Johnson, G. R., Harrisburg, died July 16, at the age of 72. He was a physician in Harrisburg since 1927, but retired 4 years ago due to ill health.

*Kaplan, Samuel, Chicago, died April 25, at the age of 73.

*Mackoff, Herman, Chicago, died August 13, at the age of 47. He was a staff member at Christ Community Hospital in Oak Lawn. Dr. Mackoff was a graduate of the Northwestern University Medical School.

*Marchlewski, Eugene F., Lockport, died April 16, at the age of 51. He was secretary-treasurer of the Will-Grundy Counties Medical Association. He was also on the staffs of St. Joseph's Hospital and the Silver Cross Hospital in Joliet.

**Mee, Lester E., Wilmette, died September 6, at the age of 86. He was a physician for more than 50 years.

**Morwitz, Samuel Mordecai, Chicago, died February 22, at the age of 85. He was on the faculty of the University of Illinois College of Medicine and on the staff of the Mount Sinai Hospital. Dr. Morwitz was a physician for more than 50 years.

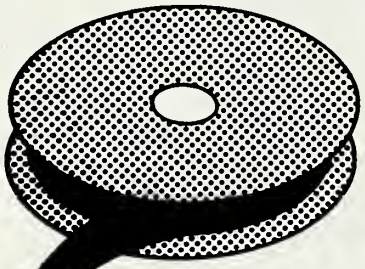
*Moussa, Della W., Chicago, died April 17, at the age of 70.

*Remlinger, J. Earl, Wilmette, died August 24, at the age of 60. He was chief of anesthesiology of the Skokie Valley Community Hospital, since its founding in 1963. He was past president of the American Society of Anesthesiologists and of the Chicago Society of Anesthesiologists. Dr. Remlinger also was an instructor at the Northwestern University and University of Illinois Medical Schools.

*Rupprecht, Fredrick Otto, Johnston City, died at the age of 54. He was a physician in Johnston City for 19 years.

**Indicates member of ISMS.*

***Indicates member of ISMS and Fifty-year Club.*



Greatest Advance Since the Typewriter was Invented! No More Smeary Erasing—Covers Mistakes Instantly, Permanently!

SELF-CORRECTING TYPEWRITER RIBBON!

Most exciting, needed advance since the typewriter was invented! As of this moment, every messy, smudgy, smeary typewriter eraser in the world hits the scrap heap for good. No more erasing—ever! Bottom half of miracle ribbon is like a magic wand that makes errors disappear before your eyes. To make corrections, just back space, shift ribbon selector and retype error. Presto! White ink makes error completely invisible. Order extra ribbons for friends. This is one gift they'll love you for! No CODs.

MAIL ORDER MART, Dept. 14
2701 Sterlington Road, Suite 132
Monroe, Louisiana 71201

Please send me the quantity of ribbons checked below. If not satisfied, I will return ribbons within 10 days for full refund.

☐ 1 ribbon $3.50 ☐ 2 ribbons $6.00

Brand Name of Typewriter—
☐ Standard ☐ Electric ☐ Portable

Name_____

Address_____

City_____ State_____ Zip_____

BLUE SHIELD REPORT FOR Illinois Physicians

Concurrent Medical Care: Its Meaning And Reimbursement of Benefits

When a patient is admitted to the hospital primarily for surgical or obstetrical care, additional benefits for concurrent medical care rendered by a physician, other than the surgeon or obstetrician, would be paid under most Blue Shield certificates if there are unusual circumstances and specialized medical care is essential to, and distinct from, the surgical or obstetrical care. Allowances vary in accordance with the type of Blue Shield certificate held by the member.

Some examples of eligible claims for concurrent medical care are as follows:

1. The patient is admitted as a medical patient and treated medically for a period before being transferred to the surgical or obstetrical service. In such cases, the physician rendering medical care should bill Blue Shield for his services to the date of transfer;
2. The patient is primarily a medical patient, and the surgery performed is a minor procedure or diagnostic in nature. In these cases, the physician rendering medical care should bill Blue Shield for the entire period of hospitalization;
3. The patient develops a post-operative condition requiring specialized medical services. In these cases, the physician rendering medical care should bill Blue Shield from the date he enters the case to the date of completion of his hospital service;
4. The patient has a medical condition requiring close supervision both pre- and post-operatively. In this case, the physician should bill Blue Shield for the entire period of hospitalization and describe in detail the condition of the patient.

Admission date, discharge date, diagnosis and the number of in-hospital daily visits made must be reported before claims can be paid. To avoid returning reports for additional information which delay payments, the questions on the Blue Shield's Physician's Service Report must be completed, e.g., "Was surgery also performed," and "If so, by whom?", even if all services performed were medical.

In most Blue Shield certificates payment for in-hospital medical care is limited to one visit per day. However, when two or more physicians render "active" and continuous medical care during a period of hospitalization, each physician submitting a report to Blue Shield should name the other physician associated on the case. *This does not include consultations.* Most Blue Shield Indemnity Certificates do not provide benefits for consultations, and only a few Usual and Customary Certificates provide such benefits. When payment is allowed the amount of payment is based on the Usual and Customary contract in force, or the Indemnity Certificate in force.

In all examples above, each physician should submit a Blue Shield Service Report form for the services *he personally provided.* By following these procedures, the physician can help us provide better service to the medical community and to our Blue Shield subscribers.

'71 Membership-Benefits Trend Evokes Confidence in Plans

A substantial increase in memberships and benefits paid in 1971 in Illinois and over the nation are emphasized in the 1972 edition of the "Blue Cross and Blue Shield Fact Book". A limited number of copies of the report are available from the Professional Relations Department, Blue Shield Plan of Illinois Medical Service, 233 North Michigan Avenue, Chicago, Illinois 60601.

Statistics from the Fact Book show that the Blue Shield Plan of Illinois Medical Service, Chicago, paid 1,079,500 claims for medical-surgical services with dollar benefits of $64,043,000—an all time high. Nationally in 1971, Blue Shield paid almost $2.5 billion to its member-subscribers. This amount was the highest annual payment in Blue Shield history.

The Plans are continually undergoing evaluations of benefits rendered in relationship to costs to subscribers. New methods of payment and areas of coverage are being developed and marketed.

The evidence of acceptance of both Blue Cross and Blue Shield prepayment indicates confidence by the public in the voluntary prepayment system for health care delivery administered by a nonprofit organization.

ASK BLUE SHIELD
. . . ABOUT MEDICARE

Inpatient Certification and Recertification Necessary Under Medicare

There have been no recent revisions in the Department of Health, Education and Welfare's regulations concerning certification and recertification of inpatients treated under Medicare.

"Physician certification and recertification is a statutory requirement for certain program benefits, and Medicare payment simply cannot be made, under the law, in the absence of such certification. Only a physician can provide legally acceptable certification regarding medical necessity to support the payment of what is literally billions of dollars of public funds under the Medicare program," according to a statement in a memorandum from Thomas M. Tierney, Director, Bureau of Health Insurance, issued October 4, 1972.

Regulations on inpatient certification and recertification were reviewed in the *Blue Shield Report for Illinois Physicians, February, 1971.* Procedures describing revisions at the time were summarized as follows:

—Payment can be made for covered hospital services only when the physician certifies and recertifies the services that are medically necessary at designated intervals of the inpatient's stay. Physician certification and recertification statements should be retained in the hospital's files where they may be verified by the intermediary whenever necessary.

—Since January 1, 1970, it has been necessary to make the first certification by the 12th day of the patient's hospitalization. The Social Security Administration requires the first recertification as of the 18th day of hospitalization. Medicare regulations further require subsequent recertification to be made at intervals established by the hospital's utilization review committee, but not to exceed 30 days.

—Medicare regulations make it necessary for certification and recertification records to contain:

(1) An explanation of the medical necessity for continued hospitalization;
(2) Estimated time the patient will have to remain in the hospital;
(3) The plan for post-hospital care.

—Certification and recertification must be signed by the attending physician or a member of the medical staff familiar with the case.

—There is no requirement that certification and recertifications be made on specific forms, so long as the hospital record contains the above information, and is available to the intermediary when requested. The individual hospital determines the method by which certifications and recertifications are obtained, and the format of the statement.

—Recertification may be part of the utilization review plan, but must include the information listed above which must be included in the minutes of the review committee.

—If recertification is necessary at a time when the whole utilization review committee cannot meet, a subcommittee may be appointed to fulfill the Medicare requirement.

—In the absence of documented physicians' certification and recertification for Medicare patients within the designated time, payments to hospitals will not be made. Hospitals are expected to obtain timely certification and recertification statements. However, delayed certifications and recertifications will be honored, where there may have been an oversight or lapse. In complying with the requirements, delayed certification or recertification must explain the delay and any medical or other relevant evidence for the delay.

Nature and Effect of Assignment Disallows Billing for Paperwork

The physician who accepts assignment cannot collect for paperwork necessary in filing a claim for services under Part B Medicare. The reasonable charge determination takes into consideration all services rendered by the physician in connection with the claim.

If the physician is dissatisfied with the Medicare payment, he may request a review, but he violates the assignment agreement if he collects or attempts to collect from the patient any amount disallowed as "more than the allowable charge". However, he may bill the patient for any amount applied to the Part B deductible, 20% of the allowable charges, and any charge for services disallowed as not covered.

The agreement to accept an assignment for one patient does not oblige the physician to accept the assignment for his other patients, nor for the patient for a later service.

An assignment is an agreement between a physician and his patient. It cannot be affected by any separate agreement in which the patient agrees to pay the difference in the amount billed and the charge determination of the Medicare carrier.

(This report is a service to the physicians of Illinois)

IMJ illinois medical journal

volume 142, number 5 november, 1972

staff

editor Theodore R. Van Dellen, M.D.
managing editor Richard A. Ott
assistant editor Joyce Sevits
executive administrator Roger N. White

special reports

1972 SAMA-MECO project 490
ISMS recommendations on health care licensure 497
Recommendations on smallpox immunization 526
Proposed outline for student notes on hospital charts 533

clinical articles

Reiter's Syndrome treated with methotrexate
Martin Szanto M.D. and Herbert Rubinstein, M.D. 467
Maternal death case report No. 8
Robert Hartman, M.D. 489
Venereal disease today, part I
L. V. Tava, M.D. 529

special articles

Selected findings of the ten-state nutrition survey
Frederick Trowbridge, M.D. 473
Underachievement and some associated syndromes
Richard S. Abrams, M.D., Michael Vanecko, M.D. and Irving Abrams, M.D. 478
Program of USDA's food and nutrition service
Edward Hekman, Administrator of Food and Nutrition Service 483

trauma center

A preview: a total emergency medical system for Illinois
David R. Boyd, M.D., C.M. 486

surgical grand rounds

Operation for lymphedema 494

features

the presidents page 452
editorials 470
ekg of the month 472
investment corner 506
pulse of the doctors wife 507
practice management 508
view box 509
clinics for crippled children 509
new pharmaceutical specialties 510
doctors news 515
membership forum 518
what goes on 522
obituaries 532

(cover by Alicia Albanese Kolton)

Microfilm copies of current as well as some back issues of the *Illinois Medical Journal* may be purchased from Xerox University Microfilms, 300 North Zeeb Road, Ann Arbor, Mich. 48106.

Published monthly by the Illinois State Medical Society, 360 N. Michigan Ave., Chicago, Ill., 60601.
Copyright, 1972, The Illinois State Medical Society.
Subscription $5.00 per year, in advance, postage prepaid, for the United States, Cuba, Puerto Rico, Philippine Islands and Mexico. $7.50 per year for all foreign countries included in the Universal Postal Union. Canada $5.50 U.S. Single current copies available at 75c.

Second class postage paid at Chicago, Ill. and at additional mailing offices. When moving please notify Journal office of new address including old mailing label with notification, if possible. POSTMASTER: Send notice on form No. 3579 to Illinois State Medical Society, 360 N. Michigan Ave., Chicago, Ill. 60601.

Pharmaceutical advertising must be approved by the ISMS Publications Committee. Other advertising accepted after review by Publications Committee or Board of Trustees. All copy or plates must reach the Journal office by the fifteenth of the month preceding publication. Rates furnished upon request.

'Original articles will be considered for publication with the understanding that they are contributed only to the Illinois Medical Journal. The ISMS denies responsibility for opinions and statements expressed by authors or in excerpts, other than editorial or allied views or statements which reflect the authoritative action of the ISMS or of reports on official actions, policies or positions. Views expressed by authors do not necessarily represent those of the Society; any connection with official policies is coincidental.

REGISTERED AIA MEDIA DATA FORM



Ampicillin, Carbenicillin, Oxacillin...

IMAGINE YOUR PRACTICE WITHOUT THEM

In 1957 Beecham scientists discovered and isolated 6-APA, the penicillin nucleus that opened the way to a new generation of semi-synthetic penicillins. Over the past 14 years more than 3000 different semi-synthetic penicillins have been synthesized and evaluated by our staff. The fruits of their work are in your hands today. Others will be in your hands tomorrow.

Need we say more?

Prescribe the discoverer's brands:

Totacillin® (ampicillin trihydrate)
Pyopen® (disodium carbenicillin)
Bactocill® (sodium oxacillin)
and more to come

Beecham-Massengill Pharmaceuticals BMP
Div. of Beecham Inc. Bristol, Tennessee 37620

☐ Totacillin (ampicillin trihydrate) capsules equivalent to 250 mg. and 500 mg. ampicillin, for oral suspension equivalent to 125 mg./5 cc. and 250 mg./5 cc. ampicillin.
☐ Pyopen (disodium carbenicillin) vials for injection equivalent to 1 gm. and 5 gm. of carbenicillin.
☐ Bactocill (sodium oxacillin) capsules equivalent to 250 mg. and 500 mg. oxacillin and vials for injection equivalent to 500 mg. and 1 gm. oxacillin.

an important one of our own

PREMARIN® contains natural estrogens exclusively!

No synthetic supplements or substitutes.

Because we feel it's the way conjugated estrogens should be made.

And it is surely one reason why PREMARIN is by far the most widely prescribed agent of its kind. And why, since the day it was introduced in 1942, it has continued to be the measure of quality among estrogen preparations.

Produced under strict quality controls, PREMARIN assures you and your patients consistency in *product potency, activity, and stability.*

PREMARIN. The complete estrogen complex. The only oral estrogen whose composition meets every specification for conjugated estrogens in the latest United States Pharmacopeia (Edition XVIII)... *and* contains natural estrogens exclusively.

PREMARIN®

BRAND OF

CONJUGATED ESTROGENS TABLETS, U.S.P.

after thirty years... still the standard for conjugated estrogens

BRIEF SUMMARY

(For full prescribing information, see package circular.)

PREMARIN® (Conjugated Estrogens Tablets, U.S.P.)

Indications: PREMARIN provides specific replacement therapy in the management of estrogen deficiency states, notably in the menopause and postmenopause.

Precautions: *In the female:* To avoid continuous stimulation of breast and uterus, cyclic therapy is recommended (3 week regimen with 1 week rest period—Withdrawal bleeding may occur during this 1 week rest period).

Failure to control breakthrough bleeding or unexpected recurrence is an indication for curettage.

In the male: Continuous therapy over prolonged periods of time may produce gynecomastia, loss of libido, and testicular atrophy.

Dosage and Administration: Cyclic administration is recommended (3 weeks of daily estrogen therapy and 1 week off).

If patient has not menstruated within last two months or more, cyclic administration is started arbitrarily. If patient is menstruating, cyclic administration is started on day 5 of bleeding.

If breakthrough bleeding occurs (bleeding or spotting during estrogen therapy), increase estrogen dosage as needed to stop bleeding. In the following cycle, the dosage level which was employed for hemostasis should be used for daily administration. In subsequent cycles, the estrogen dosage is gradually reduced to the lowest level which will maintain the patient symptom-free. (See Precautions.)

Menopause (natural or artificial)—PREMARIN 1.25 mg. daily, cyclically. Adjust dosage upward or downward according to severity of symptoms and response of the patient. For maintenance, adjust dosage to lowest level that will provide effective control. Many clinicians favor continuing cyclic estrogen replacement therapy throughout the postmenopause as a protective influence against accelerated degenerative changes at the cellular level.

Postmenopause—(If uterus is intact the patient is considered postmenopausal from one year after cessation of menstruation to end of life span.) If the presenting symptoms are those of the menopause, see above for dosage. As a protective measure against premature degenerative changes in bone and cellular metabolism (e.g. atrophic vaginitis, osteoporosis), give PREMARIN daily and cyclically. Adjust dosage to lowest effective but subbleeding level.

Estrogen Deficient Atrophic Vaginitis, Kraurosis Vulvae, and Pruritus Vulvae—1.25 mg. to 3.75 mg. daily, or more, cyclically—depending on the tissue response of the individual patient.

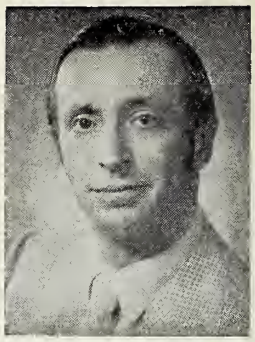
How Supplied: PREMARIN (Conjugated Estrogens Tablets, U.S.P.) No. 865—Each *purple* tablet contains 2.5 mg. No. 866—Each *yellow* tablet contains 1.25 mg. No. 867—Each *red* tablet contains 0.625 mg. No. 868—Each *green* tablet contains 0.3 mg.

Bottles of 100 and 1,000. The 1.25 mg. potency also available in unit dose package of 100.

Ayerst® AYERST LABORATORIES
New York, N.Y. 10017

7237

the presidents page



The Status of the Private Practitioner

*I*t is time we demand the federal government reach a decision concerning the status of physicians in private practice. ARE WE RUNNING A SMALL BUSINESS OR ARE WE DISPENSING A SERVICE?

*The government says that unpaid patient bills cannot be written off the physician's income tax because health care delivery is a *SERVICE.*

*Yet we are told to post our fees on the office walls as if we were dispensing the product of a SMALL BUSINESS.

*And now when price control restrictions are being removed from the majority of small businesses, we are still subject to the 2.5 percent fee increase limit. And may I add—no other profession, except the private practitioner, is subject to this severe restriction.

If we are a SMALL BUSINESS, we should be treated like one . . . with the same privileges and restrictions as other SMALL BUSINESSES. And the same equality should apply if we are dispensing a SERVICE. But I resent being volleyed between two categories and getting the short end of the stick from both!

Despite a few isolated exceptions of physicians who earn extraordinary incomes, the average physician is falling behind other Americans in hourly take home pay.

Exactly what is the physician's economic value to society? The answer to this question might decide what standards of living we deserve to enjoy.

It has been suggested that we increase our productivity to meet rising costs. Yet, the government allows union members who work from 35-40 hours a week, pay increases of 7% or more. Small businesses are permitted to pass on increases in operating costs to their customers.

But the private practitioner . . . who already works about 55 to 60 hours a week . . . is supposed to increase his productivity yet continue to limit fee increases to 2.5 percent. Is this fair?

And who determines our fees in the first place? Are we still considered independent contractors?

One San Francisco labor attorney argues that "the vision of the doctor as contracting with the private patients and fixing his own charges is no longer true." Instead, insurance carriers and prepayment plans call the pricing tune.

And the recent antics of the AETNA Insurance Company certainly reinforce this theory. They VERY DEFINITELY were trying to call OUR pricing tune!

But it's also been stated that if physicians derive their income from fee-for-service capitation or in any other manner from the public, they are independent contractors. Therefore, if they negotiate for payments as a group, it's called price fixing and that's illegal.

Who is correct?

Let's have some guidelines established now! I'm tired of the Potomac players making up the rules as they go along.

But only action begets action. Talking among ourselves won't solve the problem. Write to: C. Jackson Grayson, *chairman,* The Price Commission, 2000 M St., N.W., Washington, D.C. 20508.

He's already received my letter, but I'm sure he'd appreciate hearing from you too!

ARE WE A SERVICE OR A SMALL BUSINESS?

Ask C. Jackson Grayson for the answer!

Frank J. Jirka Jr. M.D.

caring better for her basic needs,
less confused in her thinking; no great
accomplishment for most people, but a
significant advance for the arteriosclerotic
patient with cerebrovascular insufficiency

Hydergine®

SUBLINGUAL TABLETS containing 0.167 mg. dihydroergocornine methanesulfonate, 0.167 mg. dihydroergocristine methanesulfonate, and 0.167 mg. dihydroergokryptine methanesulfonate

helps patients with cerebrovascular
insufficiency due to arteriosclerosis
do little things better

The usual dosage is four to six sublingual tablets daily. The patient's improvement with Hydergine is usually demonstrated in four to six weeks. Some nasal stuffiness due to adrenergic blockade, transient nausea or gastric disturbances have been reported with high dosages.

71-190R

SANDOZ PHARMACEUTICALS, EAST HANOVER, N.J. 07936 SANDOZ

DOCTORS STOP ULCER BLEEDNG BY APPLYING COLD TO STOMACH

Two Chicago doctors recently reported that they have been able to stop stomach bleeding, after other measures fail, by applying cold.

In tests on 50 patients, the treatment was 90% effective, reported Drs. Leslie J. Sandlow and Mitchell A. Spellberg of Michael Reese Hospital and Medical Center, Chicago.

Their report was made at the annual meeting of the American College of Gastroenterology, of which Dr. Spellberg is president.

They emphasized that the cooling technique is not an ulcer cure. Its benefit is to stop bleeding when diet, rest, antacids, and other medicines fail. Not all of their patients had ulcers; some had general stomach inflammation causing bleeding.

The 50 patients treated by Drs. Sandlow and Spellberg had not previously responded to the usual treatments and, further, were in shock or in danger of slipping into shock. Also, these patients, for this and other reasons, were not in condition for immediate surgery.

Each stomach was cooled by circulating a cold mixture of alcohol and water through a balloon that had previously been slipped down the gullet. The liquid circulated through the stomach for one-to-three days was kept at about 43°F. by a specially-built cooling machine.

Of all the kinds of bleeding on which the cooling was tried, said Drs. Sandlow and Spellberg, it "was most effective in patients with duodenal ulcer."

They recommended that a larger, randomized study be conducted to finally determine the full value of stomach cooling.

Ole'

Washington

Roundup

March 4-11, 1973

reliable pain relief without codeine.

Percodan® C II

Each yellow, scored tablet contains 4.50 mg. oxycodone HCl (Warning: May be habit-forming), 0.38 mg. oxycodone terephthalate (Warning: May be habit-forming), 224 mg. aspirin, 160 mg. phenacetin, and 32 mg. caffeine.

INDICATIONS: For the relief of moderate to moderately severe pain.
CONTRAINDICATIONS: Hypersensitivity to oxycodone, aspirin, phenacetin or caffeine.
WARNINGS: *Drug Dependence:* Oxycodone can produce drug dependence of the morphine type and, therefore, has the potential for being abused. Psychic dependence, physical dependence and tolerance may develop upon repeated administration of Percodan, and it should be prescribed and administered with the same degree of caution appropriate to the use of other oral narcotic-containing medications. Like other narcotic-containing medications, Percodan is subject to the Federal Controlled Substances Act.
Usage in ambulatory patients: Oxycodone may impair the mental and/or physical abilities required for the performance of potentially hazardous tasks such as driving a car or operating machinery. The patient using Percodan should be cautioned accordingly.
Interaction with other central nervous system depressants: Patients receiving other narcotic analgesics, general anesthetics, phenothiazines, other tranquilizers, sedative-hypnotics or other CNS depressants (including alcohol) concomitantly with Percodan may exhibit an additive CNS depression. When such combined therapy is contemplated, the dose of one or both agents should be reduced.
Usage in pregnancy: Safe use in pregnancy has not been established relative to possible adverse effects on fetal development. Therefore, Percodan should not be used in pregnant women unless, in the judgment of the physician, the potential benefits outweigh the possible hazards.
Usage in children: Percodan should not be administered to children.
Salicylates should be used with caution in the presence of peptic ulcer or coagulation abnormalities.
PRECAUTIONS: *Head injury and increased intracranial pressure:* The respiratory depressant effects of narcotics and their capacity to elevate cerebrospinal fluid pressure may be markedly exaggerated in the presence of head injury, other intracranial lesions or a pre-existing increase in intracranial pressure. Furthermore, narcotics produce adverse reactions which may obscure the clinical course of patients with head injuries.
Acute abdominal conditions: The administration of Percodan or other narcotics may obscure the diagnosis or clinical course in patients with acute abdominal conditions.
Special risk patients: Percodan should be given with caution to certain patients such as the elderly or debilitated, and those with severe impairment of hepatic or renal function, hypothyroidism, Addison's disease, and prostatic hypertrophy or urethral stricture.
Phenacetin has been reported to damage the kidneys when taken in excessive amounts for a long time.
ADVERSE REACTIONS: The most frequently observed adverse reactions include light-headedness, dizziness, sedation, nausea and vomiting. Some of these adverse reactions may be alleviated if the patient lies down.
Other adverse reactions include euphoria, dysphoria, constipation and pruritus.
DOSAGE AND ADMINISTRATION: Dosage should be adjusted according to the severity of the pain and the response of the patient. It may occasionally be necessary to exceed the usual dosage recommended below in cases of more severe pain or in those patients who have become tolerant to the analgesic effect of narcotics. The usual adult dose is one tablet every six hours as needed for pain.
DRUG INTERACTIONS: The CNS depressant effects of Percodan may be additive with that of other CNS depressants. See WARNINGS.
Aspirin may enhance the effect of anticoagulants and inhibit the effect of uricosuric agents.
MANAGEMENT OF OVERDOSAGE: *Signs and Symptoms:* Serious overdose with Percodan is characterized by respiratory depression, extreme somnolence progressing to stupor or coma, skeletal muscle flaccidity, cold and clammy skin, and sometimes bradycardia and hypotension. In severe overdosage, apnea, circulatory collapse, cardiac arrest and death may occur. The ingestion of very large amounts of Percodan may, in addition, result in acute salicylate intoxication.
Treatment: Primary attention should be given to the re-establishment of adequate respiratory exchange through provision of a patent airway and the institution of assisted or controlled ventilation. The narcotic antagonists naloxone, nalorphine or levallorphan are specific antidotes against respiratory depression which may result from overdosage or unusual sensitivity to narcotics, including oxycodone. Therefore, an appropriate dose of one of these antagonists should be administered, preferably by the intravenous route, simultaneously with efforts at respiratory resuscitation. Since the duration of action of oxycodone may exceed that of the antagonist, the patient should be kept under continued surveillance and repeated doses of the antagonist should be administered as needed to maintain adequate respiration.
An antagonist should not be administered in the absence of clinically significant respiratory or cardiovascular depression.
Oxygen, intravenous fluids, vasopressors and other supportive measures should be employed as indicated.
Gastric emptying may be useful in removing unabsorbed drug.

Endo Laboratories, Inc.
Subsidiary of E.I. du Pont de Nemours & Co. (Inc.)
Garden City, N.Y. 11530
DUPONT

IMJ
Illinois Medical Journal
Vol. 142, No. 5, November, 1972

Reiter's Syndrome Treated with Methotrexate

By Martin Szanto, M.D., and Herbert Rubinstein, M.D./Chicago

Case Report:

Reiter's syndrome is characterized by urethritis, polyarthritis and conjunctivitis. Other manifestations which are sometimes associated with this syndrome are: a) skin involvement (keratodermia blenorrhagica); b) mucous membrane involvement (oral and urethral); c) balanitis circinata; d) prostatitis; e) iritis; f) nail involvement; g) diarrhea; and h) myocarditis.[1-3] The course is variable, being marked by frequent spontaneous remissions and exacerbations, but is generally rather benign. There are patients, however, who run a protracted course with severe incapacitation and permanent joint damage.[4]

As a result of the similarity between Reiter's syndrome and psoriatic arthritis[5-7] several efforts have been made to use methotrexate in the treatment of Reiter's syndrome.[8-10] The patient presented here is one who, despite several months of conventional therapy, was still bed-ridden and in need of narcotics. Treatment with methotrexate was followed by progressive improvement.

Case History:

A 39-year-old Negro male was admitted to Hines VA Hospital in October, 1970, with chief complaint of polyarthritis involving his feet, ankles, knees and hands, since August, 1970. Several months earlier he had noticed a mild urethral discharge and a rash around the meatus. The arthritis was originally confined to his left first metatarsophalangeal joint, but four weeks later it involved both feet, ankles and knees. By the end of September his left knee was markedly swollen and excruciatingly painful. There was no history of fever or chills. During this time the patient was being followed by a physician who was unable to establish a diagnosis despite a two-week hospital stay. He was treated with various medications, including butazolidine and aspirin, with no success. Six weeks prior to admission a rash developed on his palms and soles. Three weeks later his fingernails became loose and he lost several of them.

Past medical history revealed an episode of frostbite of the right foot from which he completely recovered. For the past 20 years he had worked as a painter in an auto shop. He drank 2-4 beers daily and would occasionally have some whiskey over the weekend. He also smoked 2-3 packs of cigarettes a day for many years.

Family history disclosed that his mother was diabetic. The patient has two children who are living and well. No history of any allergies.

Examination

Physical examination revealed an alert, cooperative, well-developed and well-nourished middle-aged Negro male. At the time of initial examination he was in marked discomfort because of joint pain and unable to get out of bed. Temperature was 99°F., pulse 80/min and regular, blood pressure 120/70 mm.Hg., height 5'11" and weight 170 pounds. There was no apparent inflammation of the conjunctivae or sclerae. No evidence of iritis was seen. Fundi were normal. ENT revealed no abnormalities of the mucosa. The liver was palpable 2 cm. below the right costal margin, but the total span was only about 10 cm. Examination of the genitalia revealed the testes to be descended and normal and no inguinal hernia was present. There was a rash with a thick whitish exudate (balanitis circinata) around the meatus. There also appeared to be some degree of urethritis with a minimal discharge. Rectal and prostatic examination was normal. Examination of the back failed to disclose any evidence of sacroiliitis or painful limitation of motion of the spine. Both ankles and knees were warm and painfully swollen with effusion. The right wrist also showed similar involvement. The patient was unable to support any weight on his lower extremities. Examination of both soles and palms revealed a hyperkeratotic rash (keratodermia blenorrhagica). A thick crust was seen to be developing under the nails of the fingers and toes and there was marked pitting of the nails. No lymphadenopathy was present.

Laboratory Data: WBC 6,600 with normal differential. Hemoglobin 11.0 Gm., hematocrit 34.5. MCV 75. Urinalysis normal. Sed rate 99. LE preparations (X3), routine serology and rheumatoid factor negative. Serum chemistries included an albumin of 2.4, total bilirubin 0.4, alkaline phosphatase 140 I.U., LDH 90 u, SGOT 40 u, BSP 14%. EKG revealed left ventricular hypertrophy by voltage criteria. X-ray studies of the chest, upper gastrointestinal tract and small bowel were negative. X-rays of the pelvis, including the sacroiliac joints and lumbo-sacral spine, were normal. No changes were observed in X-rays of the larger joints, but both hands revealed mild absorption of the terminal tufts with a tapering appearance. Liver biopsy was performed and there was no evidence of hepatic cellular injury. Skin biopsy was also performed and thought to be compatible with psoriasis.

Hospital Course: Upon completion of the work-up a diagnosis of Reiter's syndrome was made. Treatment consisted of aspirin, 4.8 Gm./day, followed by butazolidine and tetracycline. A program of physical therapy was also initiated. The patient required codeine around the clock.

During the first two months of hospitalization his progress on this regimen was extremely slow and he was unable to get out of bed. All motion of involved joints continued to be consistently painful. By December it was believed that treatment with methotrexate was probably the only option open. The patient was given his first dose of 25 mg. methotrexate orally on December 29. This was followed by 20 mg. per day for the next three weeks and then 15 mg. per day thereafter.

Serial liver function studies were performed and the alkaline phosphatase declined. Serial WBCs with platelet counts were normal. Over the next two months the patient exhibited progressive improvement. The painful joint swelling and skin lesions showed regression and he had no further need of narcotics. 4.8 Gm. aspirin and 100 mg. butazolidine were initiated daily. The patient was well enough to be discharged from the hospital early in March. He was followed as an outpatient and continued on methotrexate 15 mg. a week. He has since returned to work.

Discussion

Methotrexate exerts its primary effect by inhibiting the action of the enzyme dihydrofolic reductase (DHFR). The drug has 20,000 times more affinity for DHFR than has folic acid. DHFR catalyzes folic acid and dihydrofolate into its only metabolically active form as tetrahydrofolic acid (THFA). THFA is a co-enzyme important in a variety of metabolic transformations necessary for DNA synthesis. Methotrexate affects primarily those tissues that are growing most readily. Thus, the rapid epidermal proliferation seen in psoriasis is particularly susceptible.[11]

Folic acid antagonists were first used in the treatment of psoriasis by Gubner, August, and Ginsberg (1951).[12] Since then there have been numerous reports on the treatment of psoriasis and psoriatic arthritis using methotrexate. In one of the latest papers, Kersley used oral doses of methotrexate for as long as 30 weeks in a group of ten psoriatic arthritic patients and

reported 80% improvement in the skin lesions and 50% improvement in the arthritis.[13] In general either cure or prolonged remission was obtained. Most of these cases apparently showed severe toxicity. There are in the literature at least 15 reported deaths caused by methotrexate in treatment of "psoriatic arthritis" usually as a result of gastrointestinal ulceration, bone marrow suppression, septicemia, or hepato-toxicity.[14]

This patient seemed to show clear-cut improvement following treatment with methotrexate for what appeared to be an otherwise intractable, incapacitating disease. The question of how long he will have to be continued on methotrexate and what the lowest maintenance dosage will be to hold him in remission has yet to be determined.

We must agree with other authors that methotrexate be reserved for those patients who (1) have severe, crippling disease unresponsive to conventional therapy, (2) have no specific contraindications to methotrexate (renal, hepatic, or hematologic dysfunction), and (3) have an understanding of the hazards of the drug but a willingness to accept the risk. Further evaluation is needed, especially concerning the optimal dosage schedule of methotrexate for Reiter's syndrome and the long-term prognosis for patients on such medication. ◄

References

1. Weinberg, H. W., et al: "Reiter's Syndrome, Clinical and Pathological Observations—A Long-Term Study of 16 Cases," Medicine, 41:35-91, 1962.
2. Sharp, J. T.: "Reiter's Syndrome: A Review of Clinical Features and Studies on Etiology," *Med. Clinics of N. America,* 45:1326-1336, Sept., 1961.
3. Montgomery, M. M., et al: "The Mucocutaneous Lesions of Reiter's Syndrome," *Ann. Int. Med.,* 51:99-109, 1959.
4. Ford, D. K.: "Treatment of Reiter's Syndrome," *Mod. Treatment,* 6:1140-5, Sept., 1969.
5. Wright, V. and Reed, W. B.: "Link Between Reiter's Syndrome and Psoriatic Arthritis," *Ann. Rheum. Dis.,* 23:12-20 Jan., 1964.
6. Perry, H. O. and Mayne, J. G.: "Psoriasis and Reiter's Syndrome," *Arch. Derm.,* 92:129-136, Aug., 1965.
7. Peterson, C. C. Jr. and Silbiger, M. L.: "Reiter's Syndrome and Psoriatic Arthritis: Their Roentgen Spectra and Some Interesting Similarities," *Am. J. Roentgenol.,* 101:860-70, 1967.
8. Farber, G. A., Forshner, J. G. and O'Quinn, S. E.: "Reiter's Syndrome, Treatment with Methotrexate," *J.A.M.A.,* 200:171-173, Apr. 10, 1967.
9. Mullins, J. F., Maberry, J. D. and Stone, O. J.: "Reiter's Syndrome Treated with Folic Acid Antagonists," *Arch. Derm.* 94:335-339, Sept., 1966.
10. Jetton, R. L. and Duncan, W. C.: "Treatment of Reiter's Syndrome with Methotrexate," *Ann. Int. Med.,* 70:349-351, Feb., 1969.
11. Rees, R. B.: "Methotrexate for Psoriasis," *Arch. Derm.* (Chicago) 95:2, 1967.
12. Kersley, G. O.: "Amethopterin (Methotrexate) in Connective Tissue Disease, Psoriasis, and Polyarthritis," *Ann. Rheumat. Dis.* 27:64-66, Jan., 1968.
13. Guber, R., August, S. and Ginsberg, V.: "Therapeutic Suppression of Tissue Reactivity," *Amer. J. Med. Sci.,* 221:176.
14. Psoriasis, Methotrexate and Cirrhosis. Editorial: 212: 314, 1970, *J.A.M.A.*



Martin J. Szanto, M.D. (left) is an associate attending physician at Weiss Memorial Hospital Chicago. A graduate of Loyola University Stritch School of Medicine, he is board certified in internal medicine. Dr. Szanto is a member of the American College of Physicians and has completed a fellowship in Rheumatology.

Herbert M. Rubinstein, M.D. (right) is Chief of Rhematology at Loyola University Stritch School of Medicine and Professor of Medicine. He received his M.D. from Baylor University and served internship and residency at Michael Reese Hospital.



Give More to Christmas Seals



editorials

Progress and Overcrowding

Recently, John Mirk, of Rice University in Houston, Tex., was traveling in England and was so upset by the crowded countryside that he wrote from London to the editor of *Science News*. He bemoaned the fact that "The English countryside is a totally artificial result of 250 years of exploitation" and that there are very few places which are in their wild state. The remaining open spaces were covered by pastures, wheat fields, roads, or buildings. He also noted that "Even miles out at sea the most dominant features of the coastline are smokestacks or bridges."

It was Mirk's hope that we might learn from their mistakes and not allow America's engineers, industrialists, and planners to destroy our natural areas in the same way. After all, there is nothing more refreshing than to be able to wander for miles through the forests of New England or the mountains of the west. The same can be said of state and national parks and our national wilderness preserves.

Mirk admits that these conditions are the result of "progress" and that the overcrowding of our own countryside may be inevitable . . . saving open land will not advance our quantitative knowledge, but it will give man, someday, a chance to rediscover what it was he ever invented technology for."

Britain's countryside is crowded because there are too many people. They need more space, food, shelter, transportation, and recreation facilities. Here in Illinois we are experiencing the same thing. Picnic areas are dotted with rough tables, flies, and small man-made lakes. Man can get closer to nature in forest preserves and state parks, but these areas are overcrowded and often dangerous. For economic reasons, droves of people are leaving rural areas and settling in the cities. Even the native peasants are moving to Mexico City because their relief checks are higher. The same can be said of the influx of blacks from the south.

If we blame progress, we must also blame advancements in medicine, sanitation, and public health. Paradoxically, the medical profession is indirectly responsible. All of us must die someday, but the push is on to prolong life. Our increasing population of people over 65 contributes as much to people pollution as does our birth rate. Our government should also cooperate by limiting immigration. There should be more family planning and birth control.

Meanwhile, our scientists, engineers, and industrialists should aim their guns on how man can best live with what he has. In this way, we may be able to develop pleasanter, quieter, cleaner, and safer surroundings. ◄

T. R. Van Dellen, M.D.
Editor

Guest Editorial

The Private Physician's Role in Venereal Disease Control

By Murry C. Brown, M.D.
Chicago Commissioner of Health

The effectiveness of any venereal disease control program depends upon the thoroughness exercised in the search for *all* sex contacts of any infected person.

Unfortunately, thorough epidemiology has never been given an opportunity to show its effectiveness in breaking the chain of infection, thus enhancing VD control measures. The vast majority of infected persons are never put in touch with the epidemiologic process and thus are never apprised of the benefits which may accrue to themselves and their sexual contacts.

In 1968, a "National Survey of VD Incidence" showed that more than 75% of all cases of infectious syphilis and gonorrhea are treated by private physicians. The survey also indicates that physicians report only about 10% of all VD infections seen. These studies clearly indicate that although the private physician is the key to effective control, he has not exercised this influence.

There is nothing new about the survey's figures, for they were generally assumed for many years before 1968. Public and private sectors of health care have been slinging epithets over the meaning of these statistics for years, yet the issue has not yet been solved and the public remains the loser in the battle.

In the area of gonorrhea control, the private physician often feels that reporting is not important because public health agencies do not have the funds to follow up on cases. One of the reasons public health agencies do not get the funds is that underreporting of GC cases make it difficult to establish a need in the eyes of the legislator. Lack of cooperation in this area has led to a vicious circle of low statistics and low funding. Only recently have estimated statistics been accepted and funding provided.

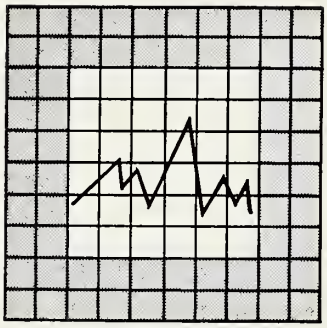
The epidemiology of syphilis has a long history with erratic effectiveness due to funding fluctuations. At the very least, the procedural aspects of syphilis epidemiology have been well tested and do yield results, but only the public clinics have provided the proving ground, while private medicine has contented itself, for the most part, to treat case by case.

The 1968 survey estimates that 55,000 infectious syphilis cases went unreported. Public health surveys show that approximately three contacts are elicited during a patient interview. Thus, we find ourselves with a possible group of 165,000 people who were exposed, yet probably never contacted and given information about what their exposure may mean to their health and their partners. Law and common sense dictate that these people have a right to know about their exposure and be allowed to follow up the possible effects of that exposure. The fact is that the rights of these people are often subordinated to the rights of the actual patient.

Traditionally, the private physician has been averse to reporting his patients to public health agencies. The very word "reporting" has unpleasant connotations. The physician often cites patient-doctor confidentiality; he fears that public health epidemiologists will expose his patient to embarrassment, and the fact that he does his own epidemiology. These are the major reasons for non-reporting by the private physicians and they must be dealt with by public health as legitimate fears and policies.

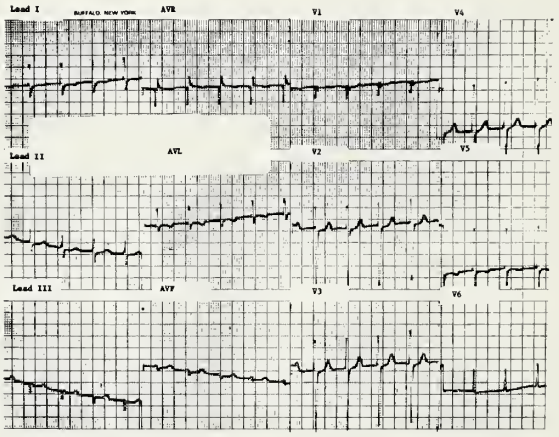
The patient-doctor confidentiality issue revolves around a fundamental question concerning the rights of the individual and the rights of society. Nothing could be said here which would end the debate, yet it must be noted that this relationship is never noted if tuberculosis or other non-sexual communicable diseases are involved. The doctor would never debate the merits of notifying relatives or friends in such cases. Therefore, the real issue is not confidentiality per se, but rather confidentiality about sex relationships. Neglect in reporting VD cases rests on the assumption that public health agencies cannot or will not handle confidentiality as a first priority once they have been contacted by the private physician.

(Continued on page 505)



ekg of the month

John R. Tobin, Jr., M.D., M.S., Rimgaudas Nemickas, M.D., Patrick Scanlon, M.D., John F. Moran, M.D. and James V. Talano, M.D./Section of Cardiology, Loyola University Stritch School of Medicine



Mr. B. is a 52 year old man who was referred for refractory congestive heart failure and a heart murmur. Cardiac catheterization confirmed the clinical impression of severe mitral regurgitation, secondary pulmonary hypertension, and heart failure. The patient was well digitalized with only slight improvement. Open heart surgery with mitral valve replacement was then performed. Post-operatively the above electrocardiogram was taken.

1. The electrocardiogram:

A. Shows junctional or nodal tachycardia.
B. Shows marked first degree AV block and sinus tachycardia.
C. Is compatible with digitalis toxicity.
D. Shows an intra-operative myocardial infarction occurred.
E. Shows atrioventricular dissociation.

2. The patient:

A. Would have distinct A and V waves in his jugular venous pulse.
B. Would be in severe heart failure.
C. Should have his digitalis withheld.
D. Should be given more digitalis.

(Answer on page 521)

Selected Findings of the Ten-State Nutrition Survey

By Frederick L. Trowbridge, M.D.

The Ten-State Nutrition Survey was conducted in 1968-1970 to assess the nutritional status of poor persons in different parts of the country (Figure 1). Ten states and New York City were surveyed, including California and Washington on the west coast; Texas, Louisiana, and South Carolina in the south and southeast; Kentucky and West Virginia in the middle eastern region; and Michigan, New York, New York City, and Massachusetts in the north.

Malnutrition was expected to be most prevalent in the segment of the population with the lowest income, so the survey sample was drawn primarily from low income areas. However, some high income persons lived within the areas selected so that data were collected on both high and low income persons. (See Figure 1.) The sample is not a random sample of the total United States or even of the specific states selected. For this reason the results of the survey cannot be extended to the total population of the states from which the samples were drawn.

Demographic data were obtained on 24,000 families containing over 86,000 persons. Included in this group were "volunteers," persons not included in the preselected sample. Further evaluation indicated that these "volunteers" did not differ in demographic characteristics from the sample individuals.

All of these individuals were invited to participate in the clinical evaluation, which included a medical history, physical examination, anthropometric measurements, X-ray examination of the wrist, dental examination, and collection of blood for hemoglobin and hematocrit determinations. This nutritional evaluation involved approximately 40,000 individuals. Selected subgroups received more detailed biochemical and dietary evaluation. Among these subgroups were high risk populations, such as infants and young children, adolescents, pregnant and lactating women, and persons over 60 years of age.

Of the 40,000 persons evaluated, 53% were 16 years of age or younger, 30% were 17-44 years of age, and 17% were 45 years of age or older.

The ethnic composition of the population examined is illustrated in Figure 2. The largest percentage of persons was white, the next largest was Black, and the third largest group was Spanish-American. The Spanish-Americans include two rather different groups: Puerto Ricans predominantly from New York City and Mexican-Americans from Texas and California. The survey also included persons of Oriental descent and American Indians.

Because adequate income is essential to the provision of adequate nutrition, income status was carefully analyzed. Since the adequacy of a given income level in providing adequate nutrition is influenced by such factors as family size, the age and sex of the head of household, and geographic region, an absolute dollar figure for income was not used. Rather, a ratio called the Poverty Income Ratio was used.[1] This ratio expresses actual family income in relation to the level of income which would be the poverty level for that particular family. Therefore, a family with a Poverty Income Ratio (PIR) of

The following three articles were presented at the Fourth Symposium on Nutrition and Food Technology, March 29, 1972, Lake Shore Club, Chicago. The symposium was co-sponsored by the Illinois State Medical Society, the Chicago Nutrition Association, and the Institute of Food Technologists-Chicago Chapter.

Frederick L. Trowbridge, M.D., is the Epidemic Intelligence Service Officer, Nutrition Program for the Center for Disease Control, Atlanta, GA.



Figure 1

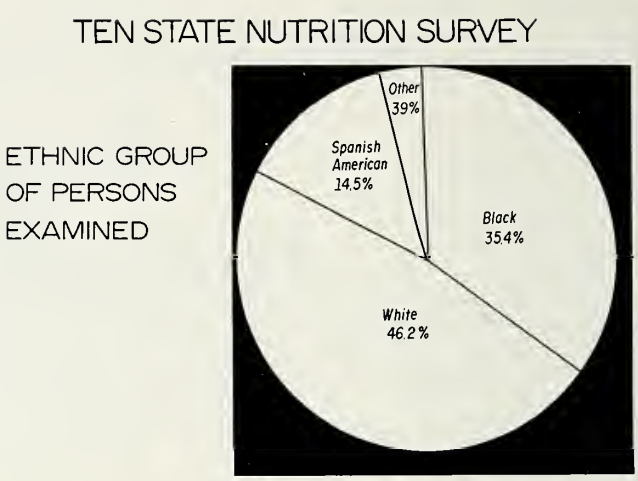


Figure 2

one has an income which is exactly at the defined poverty level. A family with a PIR of less than one has an income which is *below* the poverty level for that family.

Because of the importance of identifying the effects of economic factors on nutritional status, the states were divided into high-income and low-income groups for purposes of analysis. Figure 3 illustrates the geographic location of the two groups of states. Texas, Louisiana, South Carolina, Kentucky, and West Virginia were considered together as "low-income-ratio states" because more than half of the families surveyed in these states were living at a below-poverty level. California, Washington, Michigan, New York State, New York City, and Massachusetts were grouped together as "high-income-ratio states" because more than half of the families surveyed in these states were classified as living above poverty. Classifying these two groups of states on the basis of income allowed statistical comparison reflecting the effects of both regional and economic factors on nutritional status while maintaining enough numbers in each group to make comparisons valid.

Specific Findings

Clinical Examination:

Malnutrition must be prolonged and severe to produce obvious clinical signs. Even in underdeveloped countries, where malnutrition is a more severe problem, it is difficult to recognize specific nutritional deficiencies. For this reason it is not surprising that few severe nutritional deficiencies were identified clinically in the survey. Some signs often associated with rickets and some cases of growth failure in infants and children related to inadequate nutrition were identified; however, most of the clinical findings were non-specific. These non-specific findings do *not* indicate that deficiencies do not exist. Rather, they point to the need for supporting information concerning nutritional status from anthropometric, biochemical, and dietary evaluations.

Anthropometric Data:

Physical measurements of height, weight, and fatfold are among the most widely used indicators of nutritional adequacy. These measurements are of particular interest in children since a child's growth reflects his nutritional supply. Some of the most interesting findings were in the results of height measurements. Even though the average income ratio of their families was lower Black children were generally taller for their age than white children. This finding held true for both sexes. Furthermore, the Black children measured were generally more advanced in bone and dental development.

Analysis of weight data for children 1-12 years old led to some different findings. Although Black children were generally taller their average weight tended to be the same or even somewhat less than white children. In the adolescent period Black males weighed consistently less than whites of the same age.

The income status of the family consistently affected the growth of white children. Children from families with higher income levels were consistently taller and heavier than children from poorer families. The effect of income on growth in Black children could not be assessed in the same manner because only small numbers of Black children from high income families were measured.

Another important measurement was the triceps skinfold thickness, or more accurately, "fatfold." In infancy and early childhood Black children tended to have larger fatfold measurements, but beyond 3 years of age fatfold measurements in Black children were smaller than in white children. It was found that higher family income level was associated with greater fatfold thickness in white children. The small number of measurements on Black children from high income families did not permit a similar comparison for Black children.

Obesity is a nutrition-related problem of significant public health concern because of its association with increased rates of diabetes, certain cardiovascular diseases, and other chronic diseases. Obesity was found to be most prevalent in adult women, particularly Black women. More than 40% of women 45-55 years of age were found to be obese. Men were less frequently obese, although white males in both adolescent and adult age groups had a relatively high prevalence of obesity when compared with Black males. A final important point concerning obesity is that the prevalence of obesity tended to be greater in higher income groups for adult men although findings were less consistent for adult women. Overall the data does not support the popular misconception that poor people have "high carbohydrate obesity."

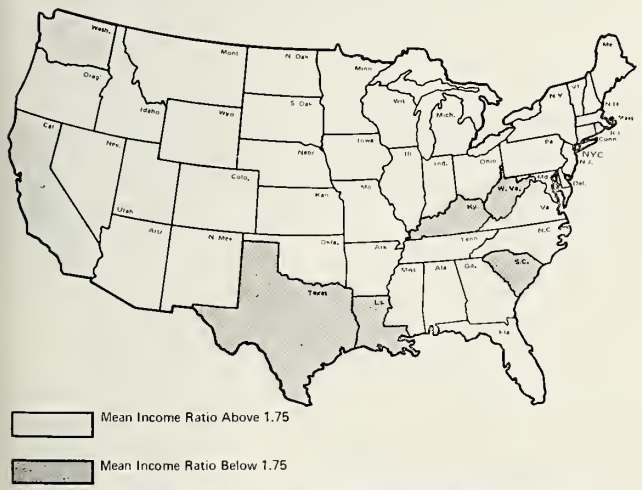


Figure 3. Low Income Ratio States and High Income Ratio States.

Biochemical Data—Vitamin A:

The results of the 22,000 vitamin A analyses showed some interesting trends. Most striking was the finding that for all races and both sexes vitamin A levels were lowest in the young and increased with age. For example, the mean serum

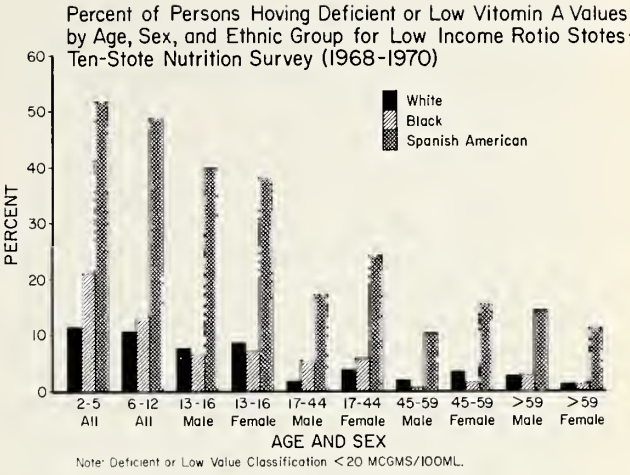


Figure 4

vitamin A concentration of infants was only slightly more than half of the levels found in adults older than 59 years of age. These low levels tended to persist up to adolescence, at which point values began to rise.

There were distinct regional differences in mean vitamin A values. In the high-income-ratio states, mean values were generally higher and there was little difference between racial groups. The low-income-ratio states mean values tended to be lower. Moreover, there were distinct ethnic differences with Spanish-Americans, in this case primarily Mexican-Americans in Texas, having considerably lower values for all age groups. Blacks in the low-income-ratio states had mean values which were generally higher than the Mexican-Americans but lower than whites.

A serum vitamin A concentration of less than 20μg/100 ml is considered to be low and to suggest inadequate vitamin A nutriture. When the data were considered in terms of the percentage of subjects with values below this level, important differences were found. The percentage of low values was greater in younger age groups for all races. Values below 20μg/100 ml were particularly frequent in the low-income-ratio states (Figure 4). Overall, 33% of Spanish-Americans (primarily Mexican-Americans), 9% of Blacks, and 6% of whites in the low-income-ratio states had values below the 20 μg/100 ml level. The prevalence of low levels was greater among persons with low incomes. In the high-income-ratio states, low vitamin A values were far less prevalent (Figure 5). Income did not play a consistent role in the prevalence of low values, and differences between ethnic groups were not as striking in the high-income-ratio states.

In summary, a significant percentage of sub-

jects evaluated had low vitamin A levels. Children and Mexican-American persons of all ages are identified as populations most at risk with respect to vitamin A nutriture.

Hemoglobin:

Hemoglobin values showed important relationships to sex and age. With slight variation, males had higher hemoglobin levels than females for all age groups beyond adolescence. As might be anticipated, the sex difference was greatest during the childbearing years. For males, mean levels were highest in the age group of 17-44 years and declined somewhat thereafter. For women, the highest mean levels were not reached until 45-59 years of age. These levels were generally maintained with increasing age beyond 59 years.

Further age and sex differences, in addition to differences between ethnic groups and geographic areas, are illustrated in Figures 6 and 7. It can be seen that hemoglobin values classified as "deficient" were found in all age groups. Males had a strikingly high percentage of deficient values, although it is critical to note that the standards used to define deficiency in males are significantly higher. Racial differences are also illustrated showing that in general the highest percentages of "deficient" values were found among Blacks, and the lowest percentages among whites.

Comparative findings for the high- and low-income-ratio states indicate that the percentage of deficiencies was higher in the low-income-ratio states but that in other respects the findings were similar. Higher income ratio level was generally associated with a lower prevalence of low and deficient hemoglobin values. However,

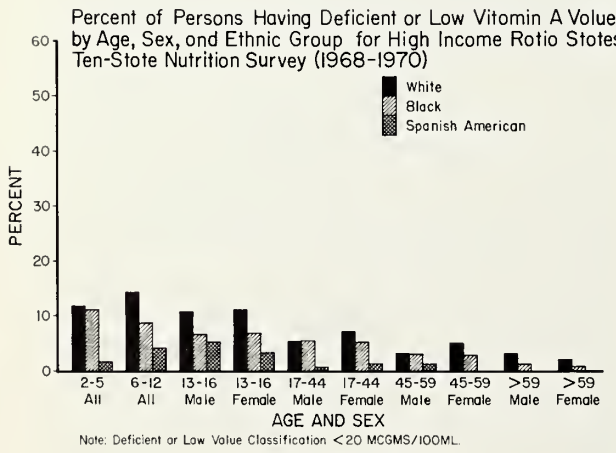


Figure 5

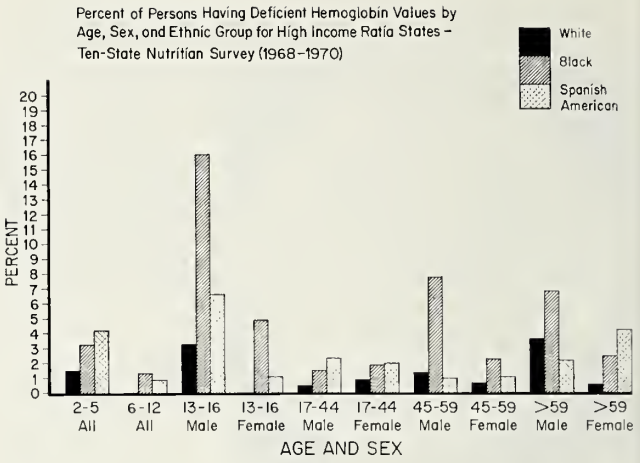


Figure 6

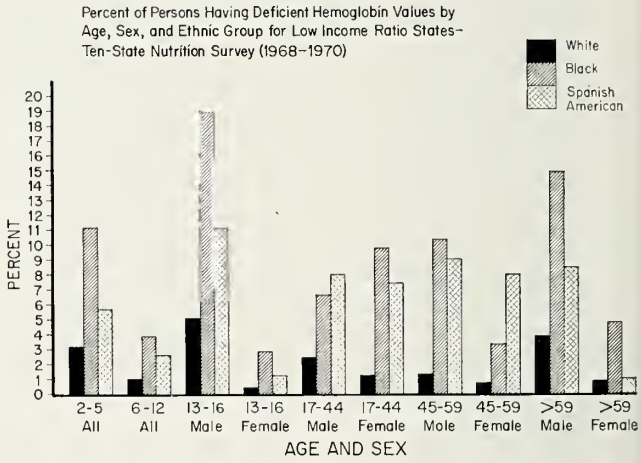


Figure 7

deficient values were found among the highest income level persons measured, suggesting that food habits, custom, and education as well as income, are important in determining hemoglobin level.

Serum Albumin:

Serum albumin concentrations are dependent in part at least on protein intakes. But albumin may also be influenced by certain pathological conditions and by pregnancy. It is important to recognize that factors other than diet may affect albumin concentration.

Serum albumin concentrations were found to vary with age, sex, and ethnic background, but showed little variation with income level. Through infancy and childhood there was little difference between male and female values. However, beginning in adolescence there were more females than males with serum albumin values below 3.5 gm%. The percentage of females with low levels increased in the adolescent age group

and reached a peak in the childbearing years. Black women showed the greatest percentage of low values. For example, in the low-income states, 18.2% of Black women age 17-34 years had albumin values below 3.5 gm/100 ml compared with 12.2% for Spanish-Americans and 4.2% for white women. In the high-income-ratio states, fewer women had low albumin levels, although Black women continued to have the highest percentage with 5.6 percent of values below 3.5 gm/100 ml.

There were significant regional differences in albumin levels. The prevalence of low values was generally higher in the low-income states for both sexes and all age groups. Black and Spanish-American ethnic groups in the low-income-ratio states were found to have a particularly high prevalence of low values.

Iodine:

Concern with iodine nutriture stems from the association between iodine deficiency and the occurrence of endemic goiter. In order to evaluate this relationship iodine excretion was compared with the prevalence of goiter found in each state area. It was found that goiter prevalence was highly variable and that there was no consistent regional pattern to high goiter prevalence (Figure 8). This is despite the fact that

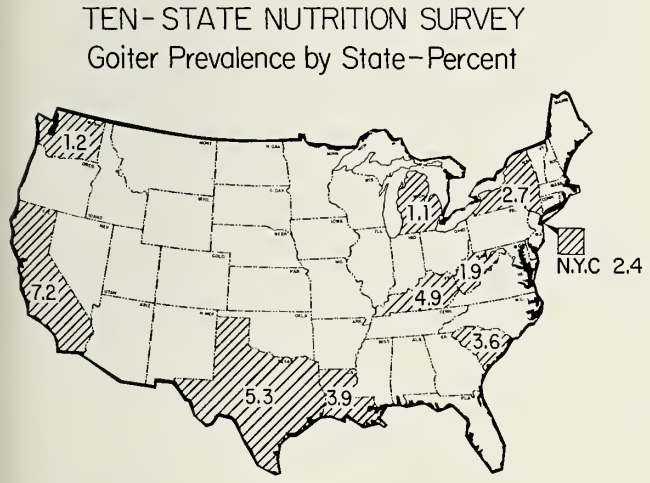


Figure 8

historically it has been suspected that there are goitrous regions or "goiter belts" where higher prevalences are found. This region has been roughly defined as extending from the Appalachian region across the Great Lakes region and continuing across the northern part of the nation to the northwest corner. It is clear that the goiter prevalence figures found in the Ten-State Survey do not reflect this historical concept of the prevalence of goiter. This finding may reflect changes in the pattern of goiter prevalence as well as shortcomings of the survey technique, such as variation in the assessment of goiter by the various examiners involved.

Table 1 lists the states surveyed in ascending order of goiter prevalence along with the percentage of persons with "deficient" and "low" iodine excretion values. There was no trend towards lower excretion in states where goiter prevalence is higher, suggesting that iodine supply was not the major determinant in the etiology of the goiter found.

The median level of iodine excretion for all persons measured was in the range of 200-250 μg/gm creatinine. (See table 1.) Measurements of iodine excretion in areas where endemic goiter is widespread often show levels of excretion which are in the range of 25 μg/gm creatine or even less.

The finding that median iodine excretion is in the range of 10 times greater than that found in areas where endemic goiter is widespread further suggests that there is little basis for suspecting endemic goiter in the population groups surveyed.

Although the population as a whole has an iodine excretion far above that which would suggest the risk of endemic goiter, some segments of the population may be relatively iodine deficient. In order to assure that all persons have adequate iodine supply, the iodization of salt remains an important public health measure.

Dietary:

Dietary evaluation provided evidence that many persons made poor food choices leading to inadequate diets and to poor use of the money available for food. In particular, many households infrequently used foods rich in vitamin A. Also, there was a heavy emphasis on meat in many diets, rather than use of less expensive but excellent protein sources such as fish and poultry, or legumes or nuts. Many diets were also deficient in iron, but this reflected less a poor choice of foods and more the generally low level of iron in the American diet. The data also showed that there were substantial numbers of children and adolescents with caloric intakes below the standard.

The school lunch contributed 30-45% of the total day's nutrient intake in the low-income states compared with 20-32% in the high-income-ratio states. In both groups of states the contribution to the day's intake was greatest among

Table 1. Percent of Persons Having Deficient or Low Iodine Values and Percent of Persons with Goiter by State. Ten-State Nutrition Survey (1968-1970)

States and New York City	Iodine Values			Goiter	
	Total[1] Number	Percent Deficient	Percent Low	Total[2] Persons Examined	Percent Positive Findings
Massachusetts	2550	0.6	2.1	3619	0.4
Michigan	1383	0.2	0.7	1947	1.1
Washington	1990	0.0	0.4	4379	1.2
West Virginia	725	0.7	1.9	1310	1.9
New York City	1160	0.2	2.8	1625	2.4
New York State	1130	0.4	1.4	2709	2.7
South Carolina	2210	0.2	2.6	3739	3.6
Louisiana	207	0.0	0.0	3932	3.9
Kentucky	1185	2.4	3.0	1362	4.9
Texas	3426	0.1	0.3	3632	5.3
California	833	0.2	0.8	4971	7.2

[1]**Computed for All Persons**
[2]**Persons Six and Over**

Urinary Iodine Deficient and Low Value Classifications (μg/gm creatinine)		
	Deficient	**Low**
All Ages	**< 25**	**25-49**

Blacks, indicating that school lunches have a particularly important role in the nutrition of these children.

Summary

Although the extensive data collected in the Ten-State Nutrition Survey were not fully evaluated at the time of writing, a number of important findings were evident. In general, clinical examination revealed few overt, severe deficiencies, although isolated cases of such conditions as rickets and growth failure on a nutritional basis were identified. Anthropometric data, specifically for children, showed that Black children were generally taller and had more advanced bone and dental development than their white counterparts. Fatness in adults as measured by the triceps fatfold was found to be consistently greater in women, reaching a peak in women 40 to 60 years of age. Adult men tended to have smaller, more constant fatfold measurements. Also, increasing income level was associated with some increase in fatness.

Biochemical determinations identified Mexican-Americans and to a lesser extent Blacks in the low-income group of states as populations with a high prevalence of low serum vitamin A values. Serum albumin values were generally lowest in women of childbearing age, particularly Black women. Iodine nutriture as measured by urinary iodine excretion did not correlate with the finding of goiter on clinical examination. Moreover, the mean iodine excretion rate was so high that endemic goiter would not be expected. However, since subsegments of the population could be relatively deficient in iodine, the iodization of salt remains an important health measure.

The findings of the Ten-State Nutrition Survey have now been published as a government report, available from the U.S. Government Printing Office. ◄

Reference:

1. Mollie Orshansky, "The Shape of Poverty in 1966." *Social Security Bulletin,* March, 1968.

Underachievement and Some Associated Syndromes

By Richard S. Abrams, M.D., Michael Vanecko, M.D., and Irving Abrams, M.D.

Underachievement is a broad term and embraces a comprehensive etiology and epidemiology. It is often associated with frustration, failure, regression and deterioration. It relates to poverty, educational retardation, acting-out, depression, and emotional illness. Underachievement is widespread, especially in urban school systems.

In June of 1971, we published "Improving The Quality of Life,"[1] in which we pointed out many conditions that lead to failure to learn, and stated, "while health plays a role, the major causes are social and economic."[2-35]

Underachievement involves mostly the low socioeconomic groups. The term *educational retardation* should be a common term because it is a widespread reality, and a serious threat to the nation's welfare. It is a pseudo-mental retardation due to a multiplicity of individual and mass social and economic deprivations.

Almost one-half of the children entering the Chicago Public School System in the primary grades are already educationally retarded.[3-7] Many continue on a path of chronic school failure. The complex aspects of learning embrace those genetic and environmental factors which operate on the thrust, direction and structure of the child. The educational structure of public school systems bears a great burden in that so many pre-schoolers enter the primary grades without the skills to enter school, let alone to compete with a more affluent peer group. Many poor Blacks have problems of inadequate home structure and inadequate income for a fair quality of living. There are Spanish-speaking families who have significant and over-riding problems of economics and language. Several poor whites have a lack of saleable skills. Numerous low socio-economic groups of people bring their young children to the entering grades with most of the family problems unsolved, all of which militate against an adequate learning and achieving situation.

Some years ago, school systems had a fairly strict policy of standards in each subject and this was reflected in a limited failure rate. Many schools abandoned the old standards because of realistic reasons and passed many children upward regardless of the achievement. Associated with failure to achieve is the "behavior" situation, to which many children in many schools are involved to varying degrees.

In January of 1970, the Chicago Public Schools City-Wide Testing results[3] of the period 1968-1969 were made public for the first time in the school system's history. This was followed a year later by a publication of the Report of the 1969-1970, City-Wide Testing Program.[36]

Table I shows the scores of the Chicago Public Schools as compared to the National Norms and also a comparison of the 1968-1969 testing to the 1969-1970 testing in terms of "entering readiness."

Table I
Entering First Year Readiness

	1968-1969		1969-1970
	National	Chicago	Chicago
Ready	69%	52%	54%
Probably not ready	24%	35%	34%
Not ready	7%	13%	12%

It is apparent that little change has taken place in a year. The lesser percent of children that are "ready" to enter school in Chicago as compared to the National percent is not a reflection of the Chicago Public School System, but rather a measure of the genetic endowment and the pre-school environmental milieu. Failure of programs at the preschool level for the low socioeconomic groups is a reflection of the inadequacies of national and community priorities.

A study of school learning ability, reading, and arithmetic computation at various grade levels shows that achievement and progress are lower than the national norms and that these criteria show a sharply lower achievement of children in low socio-economic schools as compared to those in middle and high economic schools. Furthermore, achievement on a group scale generally increases or decreases as the general welfare of the family unit and the neighborhood increases or decreases. In addition, most of any improvement in school achievement is not due on a wide scale to programs geared to education, but rather to improvement in the economic, social and political milieu of the family and the community. We are seeing this phenomenon all over the nation and the world, where the quality of general living improves.

Psychodynamics can be important to the nonachieving individual pupil. But much more is needed for low socio-economic pupils on a group and community basis.

We are not underemphasizing the genetic role. Genes determine the activity of critical proteins, their quantity or quality, or the milieu in which the proteins operate. The normal or distorted actions of a single gene can infringe on a wide variety of related actions and in this

Richard S. Abrams, M.D., Psychiatrist, Northwestern University Medical School and Attending Psychiatrist, Northwest Memorial Hospital.
Michael Vanecko, M.D., Associate Medical Director, Chicago Public Schools and Fellow, American Academy of General Practice.
Irving Abrams, M.D., Medical Director, Chicago Public Schools and Chairman, School Health Committee, Pediatric Coordinating Council of Illinois.

way influence metabolic patterns, cellular structures and morphologic units. *The role of nutrition sometimes seems cloudy, but it should be basic at the development of life into a functioning human.*

It is felt that among the many deleterious factors, *malnutrition is dangerous at important critical periods of cellular growth.* It is difficult to separate the effects of genetic, nutritional, and other environmental factors in relation to size, stature, mental health, behavior and learning.

In terms of mutant genes, Benzer[37] did most fascinating work with Drosophila, the fruit fly, and observed that some mutants produced traits of sluggishness, hyperkinesis, flightlessness, uncoordinated, non-climbing, easily shocked, freaked-out, paralyzed, parched, arrythmic, sexual habit changes, visual defects, and other abnormalities. It is obvious that the genetic individualities in humans need to be looked at as well as the favorable and unfavorable environmental influences on structure, personality development, behavior and achievement.

In appraising the drop-out situation, one must realize that standards of academic failure applied to school children at the elementary and secondary level leaned toward leniency because the problem of non-achievement was too vast to be managed in a fixed restrictive manner. This reduced numbers and percent of drop-outs. The boy or girl who drops out of high school usually has a long history of difficulty dating back at least to the early or middle elementary grades. With this in mind, we shall examine the Chicago drop-out situation.[38]

In 1960-1961, the membership in Chicago General High Schools, Vocational Schools, and Guidance Centers was 116,031 students. Of these 10,522 students, or 9.1% dropped out. In the 1970-1971 school year, the membership was 138,330. Of these, 12,533 or 9.1% dropped out. At the end of the ten year period there was no improvement in the drop-out percentage, in spite of national and local focus on the problem. A study shows that the greatest single cause of drop-out is poor scholarship and this is underachievement. If we focus on the various groups, we find that the highest drop-out rates are in the low socio-economic Blacks and other deprived minority groups and that the differences as compared to middle and high-economic whites are striking. Elliot[39] stated: "The low self-esteem engendered by discrimination, by dominant group attitudes and restrictions, requires a sense of identity as an antidote. This sense is crucial to the transformation of a minority from an aggregate of individuals bound together only by an awareness of common misery into a collectivity committed to action on the basis of shared values. The perception of one's Black self as devalued has, at least, in the past in the United States, formed early in life." Pressing problems of poverty, crime, unrest, economic instability, joblessness, and social upheavals, have uprooted the public school systems of the big cities of the country. As a result, the teaching concept of one-to-one, face-to-face, the teacher and the student, all knowledge emanating from the teacher and the students obediently listening and reacting in orderly fashion, has failed to solve today's classroom problems. William Trow et al,[40] point out that the energetic labors of those in the field of group dynamics have helped to change things, so that now it is accepted that the classroom is a social situation. In our opinion, the classroom is an extension of the home, the neighborhood, and the social and economic and political conditions that influence the teacher and the pupil. Many teachers of course understand the dynamic forces which affect the class as a group and individually and these teachers have a greater chance of success.

In this respect, Sears and Hilgard,[41] studied the teacher's role in pupil-learning and stated, "the classroom is a social situation with a power structure, including peer relationships, and adult-child relationships."

Roth and Myersburg in *Underachievement,* compiled by Kornrich[42] write about the non-achievement syndrome at the college level and cite a prevalent and consistent syndrome consisting of:

1. Poor academic achievement.
2. General self-depreciation; lack of recognition of pleasure at "being."
3. No clear system of personal goals or values.
4. Vulnerability to disparagement by others.
5. Immature relations with parents.
6. Frequent depressions.
7. Lack of insight about self and others.
8. Free-floating anxiety.

They discuss the psychodynamics of the syndrome:

"The personality organization of these students seem to follow a definite discernible pattern. There is a lack of self-boundaries which is expressed in an apparent inability to accept or reject other's evaluations, opinions, attitudes and beliefs. They seem to have no value system of their own; this is particularly so when others'

expressions are directed toward them and are disparaging. Onslaughts against self are derived also from the inability to contain affect. When feelings well up they become uncontrollable and impulsive. The impulsive expression of hostility is directed inward and rarely permitted outward expression. Thus, whether the self is attacked from the outside or from within, *the self-structure* decompensates with each new blow. Anxiety and distress are experienced. Guilt and depression tend to bind the anxiety, and the self-structure re-establishes its dynamic equilibrium. *These students report depressions which come at frequent intervals.* Each episode of depression begins outside awareness until it snowballs; functioning is impaired during these periods and is restored only after the depression subsides."

"Each experience of devaluation leads to increments in self-disparagement and the level of free anxiety. The capacities of these individuals to bind free anxiety are severely taxed due to the already excessive production of anxiety from previous disparagement. The inability to cope with the distress feeds back in terms of further self-depreciation, thus establishing a destructive circular process which tends to perpetuate the disorder."

At the teenage adolescent level, at which the problems are more confusing to non-achieving boys and girls, it is no wonder there is acting out, dropping out and the train of deleterious actions resulting.

Anna Freud[43] on the subject of adolescence feels the child is not too well equipped to go through adolescence without upheavals. She states, "we know that the character structure of a child at the end of the latency period represents the outcome of long drawn-out conflicts between id and ego forces. The inner balance achieved, although characteristic for each individual and precious to him, is preliminary only, and precarious. It does not allow for the quantitative increase in drive activity, nor for the changes of drive quality which are both inseparable from puberty. Consequently, it has to be abandoned to allow adult sexuality to be integrated into the individual's personality. The so called adolescent upheavals are no more than the external indications that such internal adjustments are in progress. . . . The 'good' children . . . signifies a delay of normal development and is a sign to be taken seriously. Analytic exploration of the 'good' child syndrome going through adolescence reveals a reluctance to grow up and this is derived not from the id but from the ego and superego aspects of the personality."

One reflects on what is normal and what is not? James Masterson, Jr. and his colleagues[44,45] did an excellent longitudinal study on a group of 101 outpatients from 12-18 years of age and a group of controls over a five year period. Their study was, in part, designed to test the theory of adolescent turmoil, which is: "the onset of puberty . . . enhancing all instinctual drives, notably the aggressive and sexual, exacerbating all previously unresolved conflicts and initiating a variety of new conflicts, produces, in the presence of a relatively weakened ego structure, a state of great emotional upheaval which is most often called *adolescent turmoil.* The psychiatric effects of this state are believed to be as follows: psychiatric syndromes when present are ill-defined, difficult to diagnose, and unstable, with patients shifting from one category of disorder to another. In addition, syndromes are transient so that often only follow-up of later developments in the patient's life can determine whether a given symptom picture had represented psychopathology or was merely an intensification of the difficulties of adolescence. A final facet of the theory suggests that this state of turmoil is so ubiquitous that it causes psychiatric symptoms to be common and transient in most adolescents."

Masterson et al, stated after their study in regard to the symptomatic patient group, "Adolescence was but a way station in a long history of psychiatric illness that began in childhood and followed its own inexorable course—a course only temporarily colored by the developmental stage of adolescence. The decisive influence was psychiatric illness, not 'adolescent turmoil'. The latter exerted its effect primarily by exacerbating and giving its own coloring to pre-existing pathology. . . ."

There was difficulty in diagnosis of the patient group, not between turmoil and illness and not between reaction of adolescence and psychiatric illness, but rather in determining the exact diagnosis of the illness. In terms of the control group, there were equally-common symptoms as among the patients, but the control group symptoms tended primarily to be those of anxiety and depression, and not the more serious psychiatric symptoms of schizophrenia, personality disorder, and character neurosis, which were common in the patient group.

Brody[46] makes an interesting statement, "the person who is helpless in the face of external

economic, political or social circumstances must devote his available energies to the here and now struggle for survival. For him the psychotherapeutic voyage of inner exploration and the examination of unresolved childhood conflicts can be *maladaptive* as well as *difficult.*" This applies to many situations of pupil underachievement. Brody quotes Rieff, in reference to the powerlessness of the poor, *"while self-realization is a goal of psychotherapy for the middle class, self-determination is the essential first step for the lower class."*

The association of the problems of puberty and adolescence with non-achievement and educational retardation is a direct outgrowth of any significant obstacle to normal growth and progress. We feel that whether the obstacle is emotional or physical or social or economic, *the educational retardation* is a wall . . . *blocking progress,* even if the health or social or economic obstacle is under management and correction. Thus, for example, if a boy has failed in high school and is found to need psychiatric attention and indeed gets it, the educational retardation can and does stand in the path of a reasonable resolution of the emotional illness. Often, this is a major factor in the failure of psychiatric treatment patterns and programs involving troubled and confused teenagers. Every day we see teenagers who are one to three years behind in their class school level and who have been to several psychiatric clinics and several psychiatrists and who still are not "making it." They may have been involved in drug abuse and/or run-away, drop-out, delinquency, sex promiscuity, gang activities and often manifesting psychiatric illness.

We feel that individuals in the overall management and teaching structure, such as parent, teacher, nurse, social worker, counselor, psychiatrist, psychologist, pediatrician and others, are indeed doing a commendable job in their own spheres, but even after adding up all the effort and results, the gaps are enormous. We feel there needs to be a profound change in national and international priorities, with goals of constructive and mature social, economic and cultural patterns.

It doesn't take an I.Q. of 160 to know that man needs many more years on earth before he can control his wild instinctual drives, and before the millennium will be with our progeny, and before man can accept man as his friend. But we must continue to plan, however faulty. We need to continue to research the enzyme systems, viruses, toxic agents, the heart, the kidneys, nutrition, emotional illness, the brain, cancer, aging processes, and so on; and to continue to plan and implement and continue to teach children and adults the best of what religion offers. We need to cease misleading those who depend on us that this plan or that will offer comprehensive service leading to security and happiness, when comprehensive service is rare.

Comment

There is widespread school underachievement, and its existence is more profound in the low socio-economic groups of boys and girls. Nutrition is basic at the formation of life, and at least, at all of the major growth and development periods. However, while the genetic and health factors are of great importance, the major deterrents to fulfillment and self-realization are social and economic deprivations.

Definitely, there is an association of poverty—faulty nutrition—neurologic deficits—low birthweight babies—school underachievement—depression syndromes—acting-out—truancy—drop-out—antisocial actions—and off-target national priorities. Pre-school programs are inadequate.

The role of "adolescent turmoil" is minor, in that it gives its own flavor to the adolescent period (a way station in the growth and development processes), but the background factors are more important in underachievement and its associated symptoms.

Educational retardation is a chronic syndrome and is a roadblock to progress, even in those who may be in rehabilitation programs for antisocial and emotional conditions. On a large scale, the needs of the social-economic deprived are group emergence into the material and educational mainstream and self-determination. Only then can self-realization on a widespread individual basis be achieved. As psychiatrists and doctors, we are engaged in rehabilitative, reorientation and reconstructive programs with individuals and small groups. However, with the vast unfulfilled basic needs of those who are socially and economically deprived, and in whom there are symptoms and syndromes directly associated with their mass deprivations, what should be the role of the psychiatrist on this national scale? What should be the role when the "here and now" needs have stirred the nation so that our society is reeling and swaying? ◄

Bibliography

A complete bibliography for "Underachievement and Some Associated Syndromes," may be obtained by writing: *Illinois Medical Journal*, 360 N. Michigan, Chicago, 60601, or calling (312) 782-1654.

Programs of USDA's Food and Nutrition Service

By Edward J. Hekman
Administrator of Food and Nutrition Service

We all recognize that the first and most fundamental need of all of us is food—by which we mean nutrition to keep us alive and well. Like you, I see daily how desperate is the struggle of the poor and underprivileged just to get enough to eat to survive.

Essentially, the programs of the Food and Nutrition Service are geared to meet the basic food needs of the poor, either through the delivery of food itself or by supplying the means to buy food.

We began the war on hunger in 1969 with a fair arsenal of weapons. In the child nutrition area there was the long-established National School Lunch Program which is observing its 25th anniversary this school year. There were also some new and virtually untested authorities for school breakfasts, non-school, and preschool feeding programs.

For families, there was the Food Distribution Program that had its beginning in the Depression years of the 1930's. For the most part, this activity was a delivery system of limited capabilities and one fraught with logistics and acceptability problems.

There was the Food Stamp Program, which had been enacted in 1964 and had grown slowly but soundly as a means of increasing the food purchasing power of poor people.

The programs themselves needed sharpening, broadening and expanding to become more effective weapons in the battle to reach more people in more places with better nutrition. In short, we needed new or refined legislative authorities, money, and more people.

One tremendous asset I found immediately when I arrived on my new job in Washington nearly three years ago was *people*. The existing programs carried with them a cadre of excellent career people at both the Federal and State levels who had been working—I might even say "struggling"— for years to make the food programs work in the face of inadequate funding and resources.

My hat is off to these people and their local counterparts in many communities who had built a firm foundation for food assistance despite the general public complacency about the state of nutrition that stemmed from the general affluence and food abundances of the late 1940's, 50's and early 60's.

This complacency was shattered in the late 1960's when the mass media told and showed the evidences of hunger and malnutrition in the United States. Growing public concern and support gathered momentum when President Nixon on May 6, 1969, did what no leader of any nation had done before—make a total commitment to the elimination "for all time" of poverty-caused hunger and malnutrition in America. Food producers, industry groups, public and private agencies and individual citizens came forward to work actively with Government in the immense task of improving and expanding effective food delivery systems for the poor.

Here's how far we've come in that effort since 1969:

* The number of people getting help either with food stamps or the direct distribution of food has jumped from 6.9 million to over 14½ million.

* The largest factor in that growth has been in the revised and broadened Food Stamp Program, which is now serving over 11 million people. Each participant is getting an average bonus—that's increased food buying power—of nearly $13.50 per month, which is more than double the amount they got three years ago.

* The foods going into the direct distribution program have been improved in variety and amount, are now being made more nutritious through enrichment and fortification, and more attractive with new, brighter, informative labels.

* Whereas in May, three years ago there were 440 counties and independent cities without any family food program available for needy residents, today there are only a few rural counties that at this moment are not offering that help.

* In May of 1970, the Congress passed landmark legislation strengthening and broadening the child nutrition programs. This legislation set a priority on reaching all needy children with free or reduced price meals in school. In January of this year, we reached 8.1 million such youngsters for the second consecutive month. That's well over twice the 3.8 million needy children that got free lunches in May of 1969.

* Significantly, between the spring of 1969 and this winter, about 7,600 schools have joined the National School Lunch Program. The foodservice industry played a role in this achievement through the provision of the lunches or components of lunches, and in the development and adaptation of equipment to permit effective food service from nearby schools or from central kitchens.

* Total participation in the school lunch program is hovering above the 25 million mark; the peak month so far this school year was 25.4 million in December (1971). It was 21.5 million in May of 1969.

* Total Federal outlays of all food assistance programs for this year ending next June 30th will be just about $3.8 billion, nearly 4 times greater than in 1969. Next year's budget contemplates an expenditure in excess of $4.1 billion. Roughly one-third of the total currently is for the child nutrition programs.

I'm proud of these accomplishments, because they are the result of all of us working together —government at all levels, all segments of the food industry, food technologists and scientists, and just plain citizens, too.



Edward J. Hekman was named administrator of the Food and Nutrition Service when it was established in July 1969 by President Nixon to be the agency "whose exclusive concern is the administration of the Federal Food Programs." Prior to his Washington appointment, Mr. Hekman was president of the Keebler Company and vice president of Valparaiso University.

The job isn't over by any means. We still have schools that don't have food service. We still have communities that don't have a family food program. And, unfortunately, we have some areas in which local apathy results in inefficient programs that deny full accessibility by all the people that need food assistance.

While we have been concentrating, as I said, on meeting the basic food needs of poor people at home and needy children in school, we have increasingly been directing attention to an aspect of nutrition that we feel merits equal priority with delivery.

That is the *quality* of our programs.

Program quality is a lot of things. It is effective administration so that the public monies are spent wisely and well to help the people that the President, the Congress and the public intended to help. It is dedication on the part of the workers in the Federal-State-local chain to see to it that needy people can get their donated foods or spend their food stamps in dignity. It is that extra effort to make the needy child with the free lunch the equal of the more fortunate youngster who pays.

The statistics that I reported earlier are significant and impressive. But our programs are really not intended to create statistics; the food assistance programs are for *people* . . . people who by and large have not previously been invited to "break bread" so to speak with the majority of Americans.

Human being have always added an intangible ingredient to their food—a "nutrient." Perhaps the knowledge that someone cares, that one can "belong," is about as important in the battle to overcome malnutrition in America as the food itself.

Program participants often write letters usually addressed to the President or to the Secretary of Agriculture. Sometimes we see letters in which the "quality intangible" I've been talking about shows through. From Blakely, Georgia, came this one:

> "I am on this Food Stamp Program and it has helped me lots in many ways. The (donated) food was good but I enjoy the food stamps best because I can get the food I want."

Or this one from Arlington, Georgia:

> ". . . I hope this Food Stamp Program will

continually last. And the social workers that are working the community has done and still doing tremendous work. I hope things remain as wonderful as they are . . ."

Just recently, we received a quite unusual "thank you." Our Western Regional office got this letter:

"You people helped us out when we really needed assistance, with food stamps. I have been meaning to pay you back as a matter of principle, and now I can. I wish to remain anonymous."

Enclosed was a cashier's check for $106—the value of a month's food stamp issuance for a family of four.

The school lunch and other child feeding programs offer even greater opportunities for bringing a coming generation into the nutritional and social mainstream. The legislation of May 1970 includes funding authorities for broad educational and training activities, and established the National Advisory Council on Child Nutrition. That Council finished its first year's work, and earlier this month submitted its first annual report in person to the President.

The council recognizes that merely supplying a child with a nutritious mean is not enough to influence his food choices significantly, and certainly doesn't develop a full concept of proper nutrition. The Council strongly recommended reinforcing the child's eating experiences with classroom nutrition education as a logical second phase. And other innovative means of education through activities outside the school would complement these efforts

So, as we continue to look for new concepts, new techniques, new foods to help overcome the problems of space, facilities, and money in the child nutrition programs, we are equally concerned with providing the extra ingredients that can make the child part of a peer group that will continue to recognize and accept good nutrition after these children move beyond our delivery systems.

There you have it . . . the programs of the Food and Nutrition Service. You are all involved with them in one way or another; they are, in the final analysis, *your* programs. They are also the programs of such people as Count Basie, Roy Wilkins, Dr. Joyce Brothers, ballplayers Luis Aparicio and Roberto Clemente, actresses Julie Harris and Rita Moreno, actors Dustin Hoffman and Ricardo Montalban; these and other widely-known personalities have all taken time out of their busy careers to tape radio messages about school lunches and food stamps. These spots have been used widely over the country—possibly you heard one without realizing that this is part of our overall efforts to enable poor people and needy children to relate to our total society. ◄

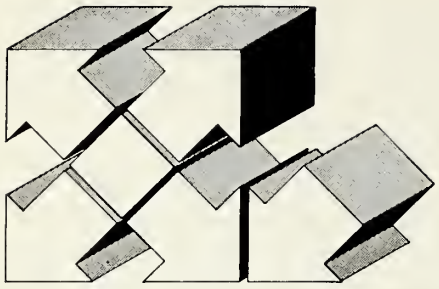
Nutrition and the American Diet

No subject in science generates more widespread popular concern than human nutrition. This is true not only in the poor, less developed countries of Asia and Africa but also in the United States and Western Europe. Among Americans, pockets of poverty produce genuine hunger and illness, infant mortality, and progressively disabling gaps in school performance. The more affluent struggle against obesity and worry about the insatiable appetites of youngsters who consume "empty calorie" snacks by the ton while ignoring all rational advice about vitamins, minerals, and adequate protein. The counter-culture fixes on the most bizarre of diets: fruit, fasting, or the brown rice of macrobiotics. At the same time, the businessman flirts with the "drinking man's diet" or battles his cholesterol level with safflower margarine, while the housewife curbs her appetite with amphetamines and "nourishes" herself with vitamin pills.

All of us put food into our bodies, and to many it becomes a mystique, a symbol, a cure, a preoccupation. Only rarely is it a guilt-free pleasure.

Science has made great strides in understanding the role that nutrients can play in keeping man healthy. The laboratory has produced valuable enrichments and fortifications for major items in the daily diet, as well as processed snack foods and advertised edibles that offer little nutrition at excessive cost. The laboratory can produce an imitation whipped cream with no food value at all, and textured soy proteins so valuable they may work a revolution in feeding the hungry. Agricultural science breeds steers with meat so well-marbled it is unhealthily rich in heart-endangering fats, but the same science breeds new high-lysine corn strains that will add critically important amino acids to meager peasant diets abroad.

A growing consumer movement in the United States demands stricter regulation of food additives, more explicit labeling of ingredients, and improved nutrition values in the marketplace. Yet millions of Americans eat fewer and fewer home-prepared "balanced" meals, while sales of pizzas, hamburgers, fried chicken, and fish-and-chips soar in the more than 30,000 franchised "fast food" outlets that crowd U.S. highways and shopping centers. (**1973 Britannica Yearbook of Science and the Future.**)



trauma center

By David R. Boyd, M.D.C.M.

A Preview:

A Total Emergency Medical Service System For Illinois

In the March, 1971 issue of the *Illinois Medical Journal,* a plan for the development of a statewide system of trauma care was introduced.[1] Later, in the Special Health Message to the State, Gov. Richard B. Ogilvie pledged his support for this program,[2] and has subsequently assisted in its development by providing whatever state resources were necessary for the success of the program. A special Division of Emergency Medical Services and Highway Safety (EMS-HS) was developed within the Illinois Public Health Department and was charged with the responsibility of coordinating state and local resources in this effort. The staff of this division includes a new health professional for Illinois, the Trauma Coordinator.[3] The trauma program has evolved through local initiatives, including hospital and professional cooperation, to develop a much improved emergency medical care, communications, and transportation system for the critically injured accident victim.

Because of the success of the Illinois Trauma Program and the momentum that has been developed to totally upgrade the quality of Emergency Medical Services (EMS) across the state, a special demonstration contract has been awarded to the Division of EMS-HS. With the change in the Areawide EMS Planning Law (PA 76-1858), all hospitals must self-designate their emergency medical capability in an areawide cooperative plan. The first such comprehensive plan was outlined in the September, 1972 issue of this journal.[4] Monies and expertise are now available in Illinois to assist local health planning in order to develop the best emergency medical care in the nation. Outlined below is a condensation of the Total EMS contract which will assist communities in their areawide planning operation and in further upgrading emergency medical services across Illinois.

An environment now exists in the State of Illinois for the development of a Total Statewide Emergency Medical Service System. The lack of provision for emergency illnesses, accidental death, and disability can no longer be classified as an insoluble health problem; medical expertise and technology are available in Illinois which can easily be applied to this previously neglected situation.

In Illinois, with the development of the Statewide Trauma Care Program, it has been shown that expert care, which was formerly available only at the university centers, can now be effectively and efficiently delivered throughout the state and especially in rural communities. The program goals of the Total EMS project and some of the new aspects to be developed are as stated below. Further details will be made available through the "Trauma Center" Section of *IMJ* and the Trauma Center Newsletter.

Program Goals:

The following is a list of program goals which will be implemented in the State of Illinois' total emergency medical service system.

Goal I. To provide accessibility and emergency medical service to all citizens of Illinois in order that they receive benefits of emergency and critical care medicine.

Goal II. To develop a comprehensive emergency and critical care system which will fully utilize existing resources while stimulating the development of new care capabilities where these are insufficient or lacking.

Goal III. To develop practical solutions to the emergency medical service problem, using accepted forms of health care application.

Goal IV. To develop all phases of the program utilizing community and areawide planning.

Goal V. To continuously evaluate and monitor programs in order to determine all critical factors and to provide for ongoing modifications and analysis.

Goal VI. To develop a total system that will be financially and administratively self-supporting without continued subsidization from external forces or reliance on a state bureaucracy.

Program Modeling:

The effectiveness of a controlled systems approach to the problems of emergency medical services has been proven in the success of the Illinois Trauma Program. This program has not only established itself as a model that many other states are now following, but has also provided the necessary groundwork for Illinois to expand its trauma care system into a Total Emergency Medical Care System. The additional financial support of the recently awarded demonstration contract can now be used to complement present planning and implementation efforts.

Communications:

Consolidating all emergency communications capability for controlled dispatching and better utilization of communications and medical personnel, is the next phase of the Illinois EMS program. The demonstration contract has provided for the purchase of approximately 900 mobile ambulance radios. The Illinois Division of Telecommunications will assist in the purchase and engineering aspects of this component of the Illinois Emergency Medical Communications Network. This ambulance-radio capability will complement the basic hospital radio system being developed by the Division of EMS-HS and the Illinois Hospital Association.[1]

Emergency Medical Transportation System:

In the development of the Illinois Statewide Trauma Program, many of the critical problems of patient transportation have been evaluated and necessary experience gained. The Illinois Emergency Medical Service System plan will rely on ground ambulance transportation for the vast majority of emergency calls. Only on rare occasions in the foreseeable future will the helicopter be utilized for this purpose. Trauma Coordinators are presently working with local governments and other responsible agencies to upgrade and expand the present ambulance service capability.

In certain cases where definitive care is beyond the scope of a primary institution to which a critically ill or injured patient is delivered, secondary transfer must be arranged. Such a transfer is sometimes extremely difficult and its success is limited by the available transportation equipment and personnel. These transfers are many times further inhibited by local jurisdictional boundaries and weather conditions. For these and other reasons, an independent, regionally-based secondary ground ambulance system is being developed.

Overland Critical Care Vans (OCCV). Overland critical care vans will be based at the Regional and Areawide Centers and will provide the ultimate in specialized intensive (life-support) care for patients while they are being transported to advanced facilities where specialized definitive care is available. OCCV's will provide an extension of the Intensive Care Unit (ICU) critical area capability of Regional and Areawide hospitals to other institutions. In the OCCV, patients will receive continued and many times enhanced critical care during transfer. The threat of loss of continuity of patient care during necessary transfers will not occur. Uniform resuscitation equipment, fluids, drugs, ventilators, and critical laboratory aids will be installed in these vans.

Outlying Critical Care Units (OCCU). Outlying critical care units will extend the coronary and other critical care capability of major hospitals to remote rural community hospitals. Satellite coronary and critical care units (OCCU's) will be "on-line" to the advanced centers for consultation and support through dedicated telephone lines for patient monitoring and dataphone electrocardiographic (EKG) transmission.

The Outreach Community Care Bus (OCCB). The outreach community care bus will be a

multipurpose mobile teaching and disaster control unit which will be used to support emergency and non-emergency health problems in special areas of Illinois.

The OCCB will be equipped to function as a mobile disaster control center. It will have radios on the EMS-HS, fire, police, and Civil Defense frequencies. The OCCB will have the capability to react to a natural disaster by rapidly moving into the area within its region and immediately becoming the Radio Command Post and Triage Center.

Training and Education:

The continued quality of health care delivery of the Illinois EMS system will be dependent on the success of the training and educational programs. These programs are being aimed at training at all levels, including allied health personnel, emergency medical technicians (EMT-A), nurses, physicians, and the public.

Emergency Room Physicians. The American College of Emergency Physicians (ACEP) is now developing a curriculum for residency training programs for emergency room physicians. Two sites, Evanston Hospital and St. Francis Hospital (Peoria), are preparing to offer such residency programs.

Trauma and Emergency Medical Services Fellows. Surgical and Critical Care Fellows at the advanced centers will receive additional post-doctoral training in trauma, burn, intensive care management, as well as bio-instrumentation, systems development, and program evaluation techniques. These Fellows will form the core of a sound, continuing community service and academic excellence for the statewide program.

Conclusion:

The Illinois Statewide Trauma Program has made great progress toward the solution of the problems of emergency medicine by bringing together many resources available within the state and tying them together into a functional regionalized network. The goal of the Total Emergency Medical Program is to capitalize on this developing system and to expand it into a full-blown system of emergency care for all citizens in Illinois. ◄

References

1. Flashner, B. A. and Boyd, D. R.: "The critically injured patient: a plan for the organization of a statewide system of trauma facilities," *IMJ,* 139:256-265, March, 1971.
2. Special Message on Health Care, Governor Richard B. Ogilvie, April 1, 1971. State of Illinois Printing Office, Springfield, IL.
3. Mains, K. D., Boyd, D. R., and Flashner, B. A.: "A new health professional: the trauma coordinator," *IMJ,* 142:158-160, August, 1972.
4. Forkosh, D. S.: "A plan for organization of emergency services on Chicago's north side," *IMJ,* 142, September, 1972.

A.M.A. Sends American Doctors to Treat Vietnamese Civilians

Another party of American physicians departed from San Francisco for Viet Nam in June for tours of duty treating patients in provincial hospitals in South Viet Nam under the American Medical Association's Volunteer Physicians for Viet Nam program.

During the seven years of its operation, the program, carried out by the AMA under contract with the Agency for International Development, has provided more than 70 U.S. civilian physicians to serve more than 900 tours in provincial hospitals in the Asian country. One-fifth of the volunteers have returned for two or more of the two-month tours.

The AMA volunteers receive only a round-trip plane ticket and $10 per day toward living expenses in Viet Nam.

The volunteers will be assigned on arrival in Saigon to provincial or prefectural hospitals, the medical school in Saigon or other medical care facilities. They will provide service in surgical and medical care of Vietnamese civilian casualties as well as other patients; assist in upgrading the national health services; teach and advise their Vietnamese counterparts, and teach Vietnamese medical students.

AID recently asked the AMA to extend the program through June 30, 1973. Some 100 additional volunteers will be needed. Further information is available through the Office of the Program Director, Volunteer Physicians for Viet Nam, American Medical Association, 535 N. Dearborn St., Chicago, Ill. 60610.

Maternal Death Study No. 8

Edited By Robert R. Hartman, M.D./Jacksonville

Case Report:

This 16 year old gravida 1 was initially seen in the first trimester at which time no abnormalities were noted. The antepartum record was not available but the physician in charge told the surveyor that no problems had been noted until the day hospitalization had been advised on account of a blood pressure of 200/100, accompanied by a ++ proteinuria and a total weight gain of 30 pounds which at no time had been unusually rapid.

At the time of admission, a highly concentrated urine specimen showed ++++ protein and while the systolic pressure had remained unchanged, the diastolic pressure had dropped to 50. Following an obstetrical consultative examination which revealed edema of the retina, spasm of the retinal vessels and pitting edema extending to the mid-thigh, the suggested plan of management included sedation in an attempt to reduce the pressure, to be followed in 24 hours by re-evaluation and either induction or Cesarian section. Two hours later, she had her first convulsion and more aggressive action was advised. One fourth grain of Morphine was given hypodermically and 5 cc of 50% Magnesium sulfate was given intramuscularly into each hip. Laboratory studies showed CO_2: 14.8, H_2CO_3: 13.1. Base deficit—15 miliequivalents per liter.

During the next five hours, she had 3 more convulsions, urinary output diminished markedly and she was continued on "magnesium sulfate, morphine, IV fluids, and close observation." Because of continuing convulsions, hypertension and oliguria and a "semi-comatose state," the membranes were artificially ruptured to start a combined mechanical-medical (syntocin) induction. Delivery occurred via outlet forceps 24 hours after admission and the patient expired only a few hours later.

Post mortem examination revealed the findings typical of eclampsia, including edema of the brain with hemorrhage into the left occipital lobe, pulmonary edema, periportal hemorrhage, membranous glomerulonephitis, and subendocardial petechial hemorrhages.

Discussion:

It is thought by your Committee that eclampsia is a preventable disease if the signs of pre-eclampsia can be recognized. To set an arbitrary limit of weight gain, blood pressure, edema, or proteinuria is to prevent proper management. Each individual must be assessed not only against overt signs and symptoms, but also prodromal manifestations. Since 70% of the cases occur in primiparous individuals and the majority in teenagers, this group must be considered as high risk in this as in other categories.

Your Committee felt that the medical team managing this case failed to recognize the potential severity of this woman's illness as evidenced by failure to use vaso-dilators in the presence of vascular spasms, diuretics in the presence of edema, to test for irritability or hyperreflexia, to discover early and treat promptly the acidosis present, or to set up the traditional environment of avoidance of external stimuli.

The autopsy findings are typical: intracranial hemorrhage, hepatic and renal abnormalities, pulmonary edema, and evidence of cardiac damage all are common in this disease. In one series of 393 cases reviewed by Donnely and Lock—180 showed evidence of brain disturbance—with almost 23% (89) having gross intracranial bleeding—133 appeared to have expired from the effect of pulmonary edema, 73 died suddenly apparently from respiratory arrest and 30 from uremia subsequent to almost complete shutdown.

Your Committee felt that earlier recognition of the severity of the disease, plus more aggressive management might have prevented this tragedy.

At the risk of seeming didactic, we submit that the teenage primagravida in particular and all primigravidas in general are more prone to develop toxemia; prodromal signs can be picked up only if watched for carefully and at frequent (weekly) intervals; and once the diagnosis of pre-eclampsia is made, treatment must be vigorous and continuous until delivery is effected.◀

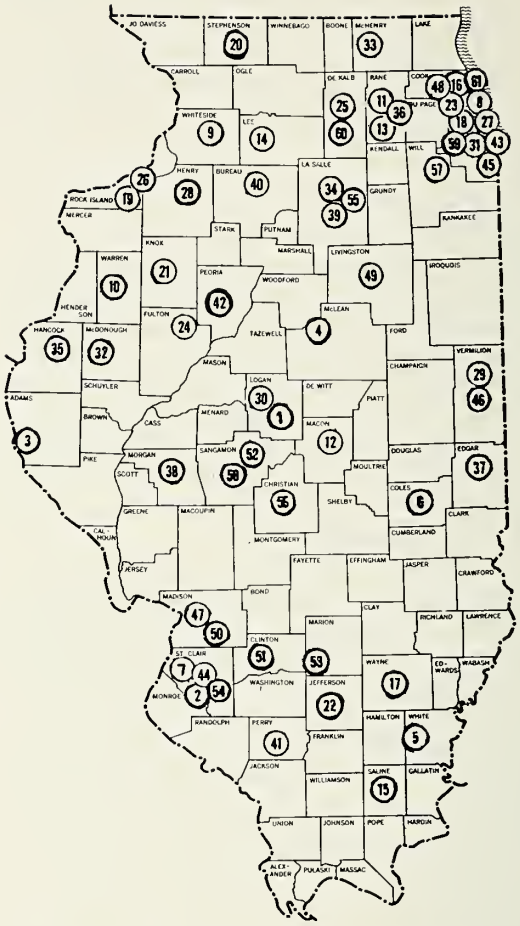
1972 SAMA-MECO Project Placed 161 Medical Students In Illinois Hospitals

The Illinois State Medical Society in co-sponsorship with the Illinois Hospital Association, Illinois Academy of Family Practice, and the Student American Medical Association will again present the SAMA-MECO (Medical Education Community Orientation) Project in 1973.

This project which will begin its 5th year in Illinois, is to provide an educational experience for students and to introduce them to medical practice in Illinois. Hospitals and Physicians have found the project provides them with a worthwhile experience as well.

In the summer of 1972, 161 future physicians learned about health care delivery first hand in 61 hospitals in the state. This was a record for the project, since it was first piloted here in Illinois in 1969, and has now grown to include over 18 states, and 1,000 students. As in the past four years, Illinois has been first in the nation and hopes to exceed this record in 1973.

The ISMS in co-operation with the Illinois Hospital Association has contacted all the hospitals in Illinois requesting their participation in the 1973 project. If any hospital has not participated in the past, or is contemplating participation, they are urged to consider this project. For further information, contact Mrs. E. Duffy, ISMS office, 360 N. Michigan, Ave., Chicago, 60601.



Locations of 1972 SAMA-MECO Programs

1972 Participating Hospitals and Medical Students SAMA-MECO Project

	Hospital, City and Physician Program Dir.	Students	School	Hometown
1.	Abraham Lincoln, Lincoln Dr. Hamm	John M. Elisberg John C. Payne Gregory Day	Northwestern U of Ill. Johns Hopkins	Glencoe Wheaton Beardstown
2.	Belleville Memorial, Belleville Dr. Harris	Steven T. Dodge Roland A. Levandowski Christopher Veremakis	Univ. of Nevada Northwestern St. Louis Univ.	Caliente, Nev. E. St. Louis Belleville
3.	Blessing, Quincy Dr. Adrian	Joseph Banno Wm. W. Greaves June H. Koizumi	U of Ill. U of Ill. U of Ill.	Oak Lawn Collinsville Chicago
4.	Brokaw, Normal Dr. Stutzman	Wm. H. Raino James R. Lister	U of Ill. U of Ill.	Joliet Shipman
5.	Carmi Township, Carmi Dr. Boren	Rod W. Perry	U of Ill.	Santa Barbara, Calif.

	Hospital, City and Physician Program Dir.	Students	School	Hometown
6.	Charleston Community, Charleston	Gary L. Berger	U of Ill.	Charleston
7.	Christian Welfare, E. St. Louis Dr. Holman	JoAnn Matory	U of Ill.	E. St. Louis
8.	Columbus-Cuneo, Chicago Dr. Nora	Royal Randolph	U of Ill.	Brunswick, Ga.
		Booker T. Galloway	Loyola	Chicago
		Joseph Chu	Georgetown	Evanston
		Ronald W. Miller	U of Ill.	Ottawa
		Thomas J. Anderson	Northwestern	Appleton, Wisc.
		Wendy Hozman	Loyola	Skokie
		P. A. Slosberg	U of Ill.	Chicago
		Elliot Frankenstein	Northwestern	Bellmore, NY
		Jac Bellis	U of La.	Chicago
9.	Community General, Sterling Dr. Greaves	J. Allen Meyer	Loyola	Chicago
		Daniel P. Del Boccio	U of Ill.	Chicago
10.	Community Memorial, Monmouth Dr. Ambrose	Robert E. Phillips	Northwestern	Clinton
11.	Copley Memorial, Aurora Dr. Donovan	Wm. Farrar	U of Virginia	Aurora
		Scott Erickson	U of Ill.	Wheaton
12.	Decatur/St. Marys, Decatur Dr. Locke	Tom Hoskins	U of Ill.	Urbana
		James Reidy	U of Ill.	Chicago
		Alan D. Bilyeu	U of Ill.	Moweaqua
		James B. Stiehl	U of Ill.	Tuscola
		Ralph Quade	U of Ill.	Decatur
		Guy Reeder	Northwestern	Decatur
		Mark Moy	U of Ill.	Chicago
13.	Delnor, St. Charles Dr. Pritchard	Richard G. Davito	U of Ill.	St. Charles
		Wm. D. Dwyer	Rush	Elgin
14.	Dixon Public, Dixon Dr. McDaniel	John G. Adams	U of Ill.	Wheaton
		David M. Harshman	U of Ill.	Rockport
15.	Doctor's, Harrisburg Dr. Tuttle	Din-On-Sun	Chicago College of Osteopathic Medicine	Chicago
16.	Evanston Community, Evanston Dr. Spencer	Leslie S. Patmon	Loyola	Chicago
		Oliver Crawford	U of Ill.	Chicago
		Kathy L. Brown	Northwestern	Boyerton, Pa.
		Joseph A. Meisenbach	U of Ill.	Reddick
17.	Fairfield Memorial, Fairfield Dr. Jannings	Jeffrey A. Hilb	U of Ill.	Chicago
18.	Forkosh Memorial, Chicago Dr. D. Forkosh	Edward Tapper	Loyola	Chicago
		Bryan C. Schultz	Loyola	Chicago
19.	Franciscan (St. Anthony), Rock Island Dr. Miller	Pamela Parke	Northwestern	San Bernardino, Cal.
		R. Kassel	U of Mexico	Rock Island
		James Savage	U of Cincinnati	Rock Island
		Jon T. Wall	U of Ill.	Monticello
		Barbara E. Burns	Loyola	Highland Park
20.	Freeport Memorial, Freeport Dr. McGath	James Rebel	U of Ill.	Shannon
		Terry L. Strawser	U of Ill.	Dowers Grove
21.	Galesburg Cottage, Galesburg Dr. Thompson	John E. Erffmeyer	Northwestern	Galesburg
		Carl S. Larson	Loyola	Everett, Wash.
		James J. Holt	Creighton	Galesburg
22.	Good Samaritan, Mt. Vernon Dr. Thompson	Doris A. Richter	U of Ill.	Mascoutah
		Jerome J. Epplin	U of Ill.	Pinkneyville
23.	Gottlieb Memorial, Melrose Pk. Dr. Portes	Steven M. Toutant	Loyola	Eau Claire, Wisc.
		Terrance L. Cascino	Loyola	Chicago
		Robert K. Zeman	Northwestern	Lincolnwood
		Robert Geller	Chicago Medical School	River Forest
		Domonic J. Catrambone	Loyola	Chicago

	Hospital, City and Physician Program Dir.	Students	School	Hometown
24.	Graham, Canton Dr. Barthelemy	Charlotte S. Yeh Martin Block	Northwestern Northwestern	Pittsburgh, Pa. Chicago
25.	Hammond-Henry District, Geneseo Dr. Parsons	Richard B. Smith Bruce Ippel	U of Ill. U of Ill.	Galena South Holland
26.	Illini, Silvis Dr. Kleinschmidt	David E. Trachtenbarg Dean R. Sharpe	U of Ill. Northwestern	Moline Fond du Lac, Wisc.
27.	Illinois Masonic, Chicago Dr. Konicek	Edward A. Pechter Dwight G. Stephens Josephine Evans L. Raymond Newcombe, Jr. Alan M. Roman Elbert Smith Andrew Cubria Eugene J. Blum Donald Bartlett Shu B. Chan	U of Ill. U of Ill. U of Ill. Loyola Chicago Medical School U of Ill. U of Ill. Chicago Medical School U of Ill. Northwestern	Chicago Chicago Chicago Winnetka Flossmoor Chicago Chicago Chicago Chicago Chicago
28.	Kewanee Public, Kewanee Dr. Terry	Kevin P. Sullivan William Prechel	U of Ill. Chicago College of Osteopathic Medicine	Chicago Detroit, Mich.
29.	Lakeview Memorial, Danville Dr. Levin	Daniel L. De Michael Steven Macke	U of Ill. U of Ill.	Chicago Marshall
30.	Lincoln State School, Lincoln Dr. Stanford	Allen Saxon	Tulane	Aurora
31.	Little Company of Mary, Evergreen Park Dr. Talso	Rita A. Vileisis Michael W. Debre Alan Kazan James A. Gianfrancisco Gregory P. Adamo Ronald E. Palmer Clement Michet Jr.	Northwestern Loyola Loyola Northwestern U of Ill. Chicago Medical School Columbia	Chicago Oak Lawn Chicago Chicago Chicago Peoria Chicago
32.	McDonough District, Macomb Dr. Pawlias	Michael Spudic Harry R. Platt	U of Ill. U of Ill.	Mt. Olive Elgin
33.	McHenry, McHenry Dr. Stein	David S. Mendelowitz George M. Gallant	Northwestern Loyola	Chicago Park Ridge
34.	Mendota Community, Mendota Dr. Wacker	Patrick J. Marmion	U of Ill.	Mendota
35.	Memorial, Carthage Dr. Eddingfield	Marvin Peiken Christopher J. Gilman Thomas A. Powers Robert Mestan	Northwestern U of Ill. U of Ill. U of Ill.	Elmont, N.Y. Watertown, N.Y. Elmhurst Chicago
36.	Mercy Center, Aurora Dr. Brill	Thomas R. Huberty Christopher A. Barbour	U of Ill. U of Ill.	Aurora De Kalb
37.	Paris Foundation, Paris Dr. Ingalls	Glen O. Gabbard	Rush	Charleston
38.	Passavant Memorial, Jacksonville Dr. Vincent	Anthony F. Molinari Lois B. Lee Mark H. Stein	U of Ill. U of Ill. Tulane	Chicago Chicago Skokie
39.	Peoples, Peru Dr. Utz	Kenneth A. Hodel	U of Ill.	Buckley
40.	Perry Memorial, Princeton Dr. Dexter	Stephanie A. Hathaway James Guetzkow	Loyola U of Ill.	E. Lynne, Conn. Evanston
41.	Pickneyville Community Dr. Stotlar	Robert L. Bernstein	U of Ill.	Chicago

	Hospital, City and Physician Program Dir.	Students	School	Hometown
42.	Proctor, Peoria Dr. Asbury	Steven Driggers Gary F. Roth	U of Ill. U of Ill.	West Frankfort Peoria
43.	Resurrection, Chicago Dr. McCarthy	David L. Massanari James Bryant	U of Ill. Loyola	Fisher Evanston
44.	St. Elizabeth, Belleville Dr. Soto	Roger W. Fox	St. Louis Univ.	Belleville
45.	St. Elizabeth, Chicago Dr. Ozdeger	Stuart Rich Edwin J. Adamski Jr.	Loyola Loyola	Chicago Northfield
46.	St. Elizabeth, Danville Dr. Walsh	John W. Beran Marshall L. Garrick	U of Ill. U of Ill.	Forrest Chicago
47.	St. Elizabeth, Granite City Dr. McLean	Michael Zich	U of Ill.	Galesburg
48.	St. Francis Cabrini, Chicago Dr. Nora	David Siegfrield	U of Ill.	Gibson City
49.	St. James, Pontiac Dr. Deterding	Ronald K. Hamburger	U of Ill.	Morris
50.	St. Joseph, Alton Dr. Vest	Michael J. Rallo Edward B. Blair, Jr.	U of Ill. St. Louis Univ.	Edwardsville Alton
51.	St. Joseph, Breese Dr. Floreza	Theodore L. Kitowski	U of Ill.	Nashville
52.	St. Margaret, Spring Valley Dr. Monroe	Scott D. Condie Wm. V. Galassi	U of Ill. U of Ill.	Spring Valley Spring Valley
53.	St. Mary, Centralia Dr. Beguelin	Ted A. Toby	U of Ill.	Bourbonnais
54.	St. Mary, East St. Louis Dr. Campos	Allen C. Bernthal Dennis Dusek	Loyola U of Ill.	St. Louis, Mo. Belleville
55.	St. Mary, Streator Dr. Goslin	Jeffrey J. Ellis Ellen S. Novotney Craig B. Thayer	Loyola Rush U of Ill.	La Grange Park Natwick, Mass. Rockford
56.	St. Vincent, Taylorville Dr. Del Valle	Robert L. Miller E. Garber	U of Ill. Northwestern	Rochester Los Angeles, CA
57.	Silver Cross, Joliet Dr. Polley	Denis Dalisky Leonard Siedband Dennis F. Dase Frank J. Rubino John R. Danielson Pedro R. Camara	U of Ill. U of Ill. Loyola Loyola U of Ill. U of Ill.	Kent, Wash. Skokie La Grange Chicago Lockport Chicago
58.	Springfield Clinic, Springfield Dr. Graham	Mark F. Swislow Nicholas P. Rollick	U of Ill. U of Mexico	Springfield Skokie
59.	Swedish Covenant, Chicago Dr. Anderson	Arnold Levin James Andrews Stuart Lancer Sherwin Ritz	Washington Univ. Washington Univ. U of Ill. Wisconsin	Wilmette Morton Grove Chicago Chicago
60.	Sycamore Mun., Sycamore Dr. Carlson	Bruce E. Carlson Charles C. Roberts	U of Ill. Chicago Medical School	Genoa De Kalb
61.	West Suburban, Oak Park Dr. Muehrcke	Tomas Bajo Frank Matheu Gregory Zych Frederick A. Klein	Loyola Chicago Osteopathic (CCOM) Chicago Osteopathic (CCOM) U of Ill.	E. Chicago, Ind. Chicago Chicago Joliet



surgical grand rounds

Edited by John M. Beal, M.D.

Operation for Lymphedema

Surgical Grand Rounds are held weekly on Tuesday at 5:00 P.M. in the Offield Auditorium at Northwestern Memorial Hospital. Patient presentations from Northwestern Memorial and the Veterans Administration Research Hospitals form the basis of the discussions. This case report was part of the Surgical Grand Rounds of May 2, 1972.

Case Report:

Dr. Robert McClellan: A 41-year-old white woman complained that her right leg had been swollen for 25 years. The swelling was noticed first with prolonged walking. Twenty years ago, with her first pregnancy, she developed bilateral varicose veins with exacerbation of the right leg swelling. In 1956, bilateral saphenous vein ligation and stripping was performed without improvement in the swelling of her right leg. She wore elastic stockings for several years. In 1965, a venogram was within normal limits. In 1971, a lymphangiogram was attempted but was not successful. Past medical history, review of systems, social history and family history were noncontributory. Physical examination: significant findings were limited to the right lower extremity. There was retained dye in the right foot from the lymphangiogram of 1971. She also had 3-plus pretibial pitting edema in the right leg. Peripheral pulses were not felt in the right lower extremity, presumably because of the marked swelling. Measurement of the circumference of the lower extremities demonstrated that there were marked differences, primarily below the knee (Table I). Blood count and urinalysis were within normal limits.

Because we could not feel the pulses of the right leg, the patient was studied in Dr. Yao's vascular laboratory. He found that the pulsatile blood flow in the right leg was normal. A venogram was also normal. On April 17th, an operation was performed which has been referred to as the Thompson Procedure, (Figures 1-4). Ten days post operatively, new measurements revealed a diminution in size of the right lower extremity, (Table I). (The patient was presented.)

Table I

	Right Leg		Left Leg	
Area of Leg	Pre-op.	10 days post-op.	Pre-op.	10 days post-op.
Mid-thigh	20"	20"	20"	20"
10 inches above medial malleolus	15"	13½"	13"	12¾"
7 inches above medial malleolus	13½"	12½"	11"	11½"
3 inches above medial malleolus	10½"	9½"	8½"	9¾"

Comparison of circumferences in inches of right and left legs before and ten days after operation at several levels.



Figure 1: Pre-operative enlargement of the right leg due to primary lymphedema.



Figure 2: A split thickness skin graft is removed. The resultant dermal pedicle buried along the deep vessels of the leg in juxtaposition to the deep lymphatics.

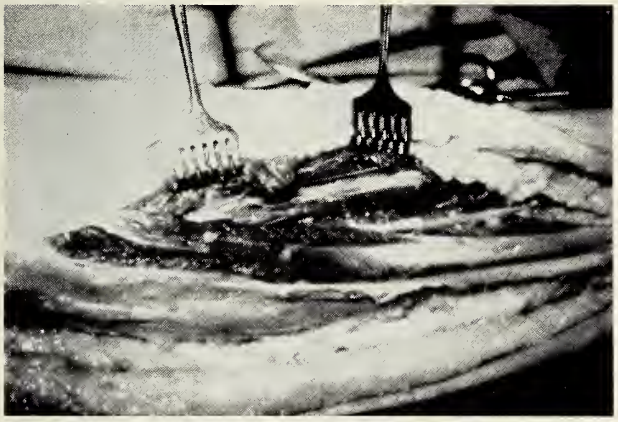


Figure 3: Deep fascia and muscles incised to expose the deep vessels. Note the absence of lymphedema.



Figure 4: Wound closure. A large hemovac is inserted beneath the flap and placed on continuous suction. Extremity is dressed with compression bandage. Three months later, the medial side will be done in a similar fashion.

Dr. Norman Hugo: The incidence of lymphedema is unknown, but it is much more common in tropical zones than in temperate zones. It is called either primary lymphedema, a euphemism for the fact that we do not know why these patients have the disease; or secondary lymphedema, the disease resulting from a specific insult. In tropical zones, it's usually secondary lymphedema due to filarial infestation. It's said by the World Health Organization that there are a million new cases of this in the tropics. The incidence in the temperate zones in the United States is unknown. The severity can vary from a mild cosmetic inconvenience to a serious life threatening disease from cellulitis or the Steward-Treves syndrome with its attendant lymphangiosarcoma.

A point that should be stressed in lymphedema is that the superficial lymphatics are involved. That is, tissues deep in the muscle fascia are spared; the lymphatics contained therein are functioning normally. Those lymphatics superficial to the muscular fascia are involved in the disease. This is the basis for two of the four presently employed operations. Briefly, there is a lymphaticovenous shunt which has been used experimentally. The technique is to anastomose a hemi-sected lymph node to an adjacent vein. It has functioned as long as nine months in dogs; it has worked in humans for approximately two months. The lymphatic tree is normally connected to the venous tree only at the juglar areas and three other areas, the popliteal and abductor area of the leg and the supratrochlear area of the arm. This is an attempt to add another area of venous communication, hopefully to encourage lymphatic drainage.

Another method uses a large tongue of omentum which is tunnelled into the arm or leg. I have had no personal experience with it. The incidence of complications is relatively high and includes bowel obstruction and evisceration. It was used on the theoretical basis that it contained a rich supply of lymphatics and a good vascular supply. I have never seen any clinical results from this method. The other two operations are based primarily on the fact that the disease is confined to the area superficial to the muscular fascia. In one, the skin and subcutaneous tissue is removed down to the fascia and this area is then grafted. It was modified by Gibson and Tough in Scotland who used the skin from the removed specimen for the grafting procedure.

Finally, the procedure you saw today. A dermal flap is placed near the deep lymphatics running in juxtaposition to the deep vessels. The operation is possible because dermal elements such as hair follicles and sweat glands do not regrow when they are buried. The superficial lymphatics within this pedicle will continue to anastomose and increase their function over the next nine months to one year. So, the result is not final from what you've seen today. It should continue to improve. It is a two stage procedure and the medial aspect will be done three to four months from now when Mrs. S. returns.

This operation has been done on the arm. A patient whose arm was operated on recently, has reported softening of the arm and a reduction in size. The complications of this operation are recurrent episodes of cellulitis and a failure to relieve the lymphedema. In these cases, we then resort to the Gibson-Tough Procedure even though you give the patient a plus-four's appearance. The results, at least in my hands, I think are better in the upper extremity than in the lower extremity. In the lower extremity, the lymphedema is primary with hypoplasia or aplasia of the lymphatics diffusely involving the extremity. In the arm, the lymphedema is invariably secondary and the obstruction is localized to one area, the axillary. ◄

OLE!

Washington Roundup Goes South

The Illinois State Medical Society's 1973 Washington Roundup, March 4-11, will feature something new—a combination vacation and educational seminar in Puerto Rico.

This year's "Roundup" will open in Washington with a reception on Sunday evening, March 4. The Washington portion of the program will also include: an AMA staff briefing on national legislation; personal visits with Illinois Congressmen; and a Congressional Reception.

ISMS staff is working with the Puerto Rico Medical Association to develop a medical program for your stay in Puerto Rico. A reception has been arranged for your arrival in San Juan.

Mark your calendar now for what promises to be one of the most informative and exciting Roundups to date. For further information please contact the ISMS Governmental Affairs Division, 360 N. Michigan, Chicago, 60601.

ISMS recommendations on Health Care Licensure

On September 10, 1971, Governor Richard Ogilvie signed into law a bill creating the Health Care Licensure Commission. This commission is charged with studying the health licensure process in Illinois and suggesting improvements in the Department of Registration and Education, as well as the practice acts governing the licensed health professions. Its recommendations will be made to the Illinois General Assembly by March 1, 1973. The following testimony, prepared at the direction of the ISMS Board of Trustees and approved by the Executive Committee, was presented to the commission by ISMS President Frank J. Jirka Jr., M.D., on September 13, 1972.

I. National Licensure of Physicians

In recent years, there has been increasing support for national licensure of physicians. By placing control for physician licensing in the hands of a centralized federal agency, advocates believe we could eliminate all reciprocity problems and insure full geographic mobility to physicians.

ISMS opposes national licensure because:

A. It would require an amendment to the Constitution of the United States. Traditionally, licensing has been a function of the state through the 10th amendment which provides that powers not delegated to the federal government are reserved to the states.

B. It offers no guarantee of high quality of physicians. In fact, if authors of the proposed national licensure plan followed the recommendations of the *1967 President's National Advisory Commission on Health Manpower,* it would establish *minimum* requirements for licensure. While some states may have to compromise to attract physicians, we do not believe Illinois has to resort to lowering its standards and jeopardizing the quality of care in Illinois.

The answer, we believe, lies in persuading states to establish uniform standards of high quality for licensure and interstate endorsement. And the increasing acceptance of the FLEX exam as a criteria for judging a physician's competency is already paving the way for this. To date, 41 states have recognized the FLEX exam.

Therefore ISMS supports the concept of the state medical examining committee, as presently constituted, and believes its preservation is in the best interest of the public as well as physicians.

II. Department of R & E

ISMS commends the Department of Registration and Education for its recent efforts to expedite licensing of health professions through the establishment of a new health section under a Deputy Director of Health.

In the past, all 33 licensed occupation processing sections utilized the same offices and administrative personnel. As a result, no priority was given to the 11 health professions, thus creating inefficiency and delay in their licensing.

We believe the establishment of a new health section, responsible only for the licensing and administrative work of the 11 health professions, is certainly a step in the right direction. However, to succeed it will require adequate staff and budget. To date, this has not been provided. No matter how talented and knowledgeable the Deputy Director may be, he cannot administer the responsibilities of the new health section alone.

When the Medical Practice Act was amended in 1957 to require renewal of physician licenses every two years, the Stratton Administration assured ISMS and the Medical Examining Committee that the income generated by renewals would be used by the Department of R&E to increase its staff and improve services in the medical licensing section.

The Kerner Administration made the same promise in 1963 when the state raised the license renewal fee from $6 to $10. Instead of being allowed to use this money to improve services in the medical licensing section, however, the Department (which takes in $3.5 million a year from licensing and renewal fees) is forced to return $300,000 to $400,000 annually to the state's general fund.

Since the Department is not a revenue raising agency, this generation of excess funds raises serious constitutional questions. To alleviate these questions, and fulfill past promises, these excess funds should be used to provide services to the licensees and applicants involved.

ISMS recommends that the Bureau of the Budget appropriate to the Department of R&E all funds generated by this department. We further recommend that the Department utilize the increased budget to provide its new health section with a sufficient staff to:

A. Provide timely and efficient service in the processing of applications for licensure;

B. Provide well informed, FULL-TIME, legal services to the examining committees.

III. Public Representation on Examining Committees

It has been proposed that the state add public representation on all health profession examining committees to reflect the needs of consumers and other health care providers and ensure greater public accountability for committee actions.

Advocates of this proposal contend that the addition of well-qualified laymen and members from other health professions would provide checks and balances and lessen the possibility of arbitrary committee decisions on individual applicants. ISMS questions the advisability of public members on examining committees.

What contribution could a consumer make in reviewing applications? Frankly, we believe the determination of an applicant's capabilities is not within the competence of non-professionals.

ISMS recommends that the Governor appoint a single advisory committee of public members to consult with and advise all health profession examining committees on policy matters. We believe such committee would provide for the needed checks and balances without hampering the committees with public members.

IV. Joint Practice Committee

In his *Cooperative Study of Health Manpower Licensure Rules, Regulations and Procedures,* (Jan. 31, 1972) Mr. Ralph Pratt recommends that the Department of Registration and Education should "organize . . . a joint practice committee composed of representatives of (all) the examining committees, providers and provider institutions for effecting expanded and efficient utilization of health manpower."

ISMS agrees that such committees are valuable in solving problems concerning the *changing* roles of existing health professions. We are not convinced that a joint committee involving "representatives of the examining committees, providers and provider institutions" would be practical. For instance, neither a dentist nor a podiatrist would be concerned with the use of LPNs as charge nurses in ECFs. Yet—if a joint committee such as Mr. Pratt recommends is established—these representatives would discuss this problem. This is a waste of time and manpower.

It would be more practical to establish several joint practice committees comprised only of those persons or organizations which would normally be expected to work together. Along this line, the medical and nursing associations in several states—including Illinois—have formed a joint practice committee. In California this committee has been expanded to include licensed practical nurses as well.

ISMS recommends that the Department of Registration and Education direct health professional organizations to form joint practice committees wherever practical . . . and offer whatever aid is necessary to implement the recommendations of these committees.

V. Establishment of Medical Disciplinary Board

Theoretically, enforcement of the Medical Practice Act is the responsibility of the Medical Examining Committee. However, the committee is so inundated with day to day work involving registration and examinations that it has little opportunity to get involved in disciplinary problems.

Result? An inefficient, ineffective system that allows incompetents to practice with little, if any, restrictions.

When this problem was brought to the attention of ISMS physicians in a 1969 membership poll, 77% of the respondents approved legislation establishing a state medical disciplinary

board—separate from the medical examining committee—to investigate physicians suspected of serious misconduct.

The proposed board, comprised of physicians authorized to suspend or revoke licenses, has precedence in the state of Washington, where it has operated successfully since 1955.

The Washington Medical Disciplinary Board has unusual strength. Its powers are clearly defined in state law, which describes a broad spectrum of transgressions over which the board has jurisdiction. It can act against doctors who are chronic alcoholics, drug addicts, incompetents, etc.

The disciplinary board, elected by physicians from each congressional district, enjoys legal immunity for its acts and receives an appropriation for operating expenses. In addition, it can call upon the services of state-employed investigators and lawyers to help it check complaints and bring legal actions.

Our legal counsel advises us that the establishment of such disciplinary board in Illinois is constitutional, requiring only enabling legislation.

ISMS recommends establishment of a state medical disciplinary board—separate from the medical examining committee—to investigate physicians suspected of incompetency or serious misconduct. The board should be provided with the necessary staff and budget to enable it to function effectively.

VI. Re-examination for Licensure

To assure the continued competency of physicians, it has been suggested that the Medical Practice Act be amended to require periodic re-examination of physicians. In its *1971 Report on Licensure and Related Health Personnel Credentialing,* the U.S. Department of HEW points out the problems involved in re-examination:

"Relicensing physicians and other health professionals who have entered into specialties presents the problem of what should be examined—the broader field, as at the point of initial licensure, or only the specialty field. Even with many years of experience, the most skillful specialist may be poorly equipped to pass a new licensure examination in general medicine. (On the other hand) there may be some question, though, whether the practitioner who is examined for continuing proficiency in a specialty only . . . should be licensed as a general practitioner."

In addition to its being discriminatory, ISMS believes re-examination would be:

A. *Impractical.* The logistics of re-examining 15,000 physicians—even if broken down to 5,000 physicians per year for 3 years—would create a tremendous administrative headache and require the addition of hundreds of employees to the state's payroll.

B. *Costly.* Consider the amount of staff, time, effort and expense for committees to prepare all the examinations needed for different types of practice. Then they would have to be checked over for accuracy, tested for validity, administered, corrected and evaluated. How much would this program cost Illinois taxpayers?

C. *Exacerbate the Physician Shortage Problem in Ghetto and Rural Areas.* Certainly no exam could retain the credibility of the public if all physicians passed it! But what of those who failed? Would they be deprived of their livelihood . . . and their patients deprived of their care? With Illinois already short of physicians in rural and ghetto areas, enactment of such provision would only add to the shortage in these areas.

While two states have tightened their licensure laws by requiring continuing education for re-registration—and seven others are exploring the idea—it is significant that *not one state* in the entire country requires re-examination for continued licensure.

If Illinois were to become the only state to require re-examination, it would seriously hamper our efforts to recruit physicians . . . and encourage those currently residing in Illinois to relocate in states with less stringent requirements. This would surely invite a physician shortage problem.

Therefore, ISMS opposes re-examination of physicians as a requirement for re-licensure.

VII. Continuing Education and Relicensure

ISMS concern with continuing medical education is evidenced by two significant actions taken this year: (1) Its establishment of an Illinois Council on Continuing Medical Education designed to stimulate, motivate and encourage Illinois physicians to participate in formal CME programs; and (2) Its establishment of an accreditation program for community hospital CME activities in Illinois, with local focus and scope.

To assure physician participation in programs such as these, the *President's National Advisory Commission on Health Manpower* recommended in 1967 that "relicensure should be granted either upon certification of acceptable performance in continuing education programs or upon the basis of challenge examinations in the practitioner's specialty."

While ISMS endorses the concept of continuing education, there are a number of problems to be considered in making it a requirement for relicensure. As HEW points out in its *1971 Report on Licensure and Related Health Personnel Credentialing:*

"What would occur if a significant number of practitioners, especially older persons, fail to qualify or choose not to apply for relicensure? Is the manpower system sufficiently strong to compensate for these potentially sizeable reductions? There are also questions of cost and logistics. Mandatory education programs will require considerably more financial support and professional time—for teaching, attending courses and administering the program—than are now committed. While some costs could easily be borne in the case of some professions, it may not be feasible for other relatively low-paid categories of health personnel.

A requirement for continuing education could also aggravate the problems of coverage for remote, underpopulated areas. Such a requirement would tend to influence the practitioner to remain conveniently near continuing education facilities and programs, resulting, in effect, in a life-long dependency on education institutions. Practitioners in remote areas may be either unable or unwilling to effectuate such basic changes in their career styles."

While not insurmountable, the problems raised by HEW should be resolved before considering licensure restrictions that could adversely affect health care delivery.

We recommend that the State of Illinois join ISMS in co-sponsoring a joint study to determine the feasibility of requiring continuing education as a pre-requisite for relicensure.

VIII. Reciprocity

Critics of Illinois' reciprocity regulations alleged that "highly qualified" physicians are prevented from practicing in Illinois because it requires a clinical competence examination. We challenge this statement because—according to the Department of R&E—some 1,465 physicians were licensed during the calendar year 1971 in the following manner:

394 by endorsement of the National Boards
285 by endorsement of the FLEX
495 by passing the FLEX in Illinois
81 by eminence
210 by passing Part III (clinical competence) of the National Boards.
Of the total applicants, 76 did not possess FLEX and did not pass Part III.

That means only 76 physicians—or about 5 percent of the original applicants for licensure—were denied a license to practice last year. Does it pay to lower our standards to accommodate this 5 per cent whose competence is questionable?

It may be true that the very existence of a "clinical competence" exam may have discouraged others from applying. The fact remains that, had they applied, most of them would have qualified for licensure by eminence if they were board certified . . . a fellow in a specialty academy . . . served in any teaching capacity . . . or been widely published.

Even if Illinois removed its clinical competence examination, it would not necessarily assure us many more physicians, for the American Medical Association reports that "no evidence would indicate that complete interstate reciprocity would alleviate any current inequitable interstate distribution of physicians in the U.S."

This was substantiated by HEW in its *1971 Report on Licensure and Related Health Personnel Credentialing* in which it states:

"There is no way of predicting whether qualified health personnel would move to areas deprived of health services if certain existing licensure requirements were abandoned. At the Department's recent Working Conference on Health Personnel Licensure, some concern was expressed that a system of nationwide recognition of the licenses of other states might, in fact, aggravate the growing problem of geographic

maldistribution. Attractive environmental conditions as well as cultural, educational and recreational facilities are frequently as important in stimulating mobility as career and income factors."

In addition, Illinois has made three significant changes in its licensure laws since 1967 that have facilitated reciprocity:

A. *Eminence.* In 1967, a discretionary clause was added to the Medical Practice Act allowing the Medical Examining Committee to grant licensure by eminence. This excuses many physicians in medicine, eminent in their fields, from having to follow the customary examination proceedings.

B. *Citizenship.* Many more physicians were attracted to Illinois as a result of the 77th General Assembly's action by which it eliminated from the Medical Practice Act requirements the stipulation that applicants had to be citizens of the U.S. or in the process of obtaining their citizenship.

C. *Six-Month Permit.* Physicians licensed in states sharing reciprocity with Illinois are now allowed to practice in Illinois up to six months while awaiting endorsement or an examination.

In 1971, the ISMS Board of Trustees and House of Delegates affirmed their support of the state's existing regulations on reciprocity. We believe this policy is fair and equitable. Any relaxation of standards would seriously dilute the high standards of care in Illinois. Since developments in the medical licensure field are moving at such a rapid pace, however, ISMS believes a study of licensing procedures, standards, rules and regulations of other states would prove valuable.

ISMS recommends that: (1) Illinois maintain its current standards with respect to reciprocal licensing of physicians; and (2) the Department of R&E conduct a study of licensure procedures of other states. Based on results of this study, Illinois should consider issuing licenses to candidates from those states which meet Illinois' standards.

IX. Permit Physicians

In 1967, the *President's National Advisory Commission on Health Manpower* charged that foreign medical graduates, with less education and lower test ratings than those required of U.S. graduates, are allowed to assume patient care responsibilities.

It points to the fact that the examination of the Educational Council for Foreign Medical Graduates is easier than that of the National Board. The scores of foreign graduates on state board examinations are poor; even after training in this country, examinations which were passed by 96 percent of U.S. graduates were passed by only 40 percent of foreign graduates, the commission noted. The commission report continued:

"This figure has added importance because those who do not pass frequently remain in the U.S., working in jobs for which the requirements for licensure are waived, e.g., many states (including Illinois) do not require that physicians in state hospitals be licensed."

The Illinois Department of Mental Health currently employs about 250 "permit" physicians in its hospitals—*many of whom have not even passed the ECFMG examination!* ISMS finds it inconceivable that the Department would entrust its patients to men who cannot even qualify for intern and residency training.

The President's Advisory Commission recommended that foreign-trained physicians who have responsibility for patient care be required to pass tests equivalent to those of graduates of U.S. schools.

The ISMS House of Delegates supported the commission recommendation in 1970 when it urged that state mental hospitals be required to maintain the same standards as private facilities. In 1971, our House of Delegates recommended that permit physicians be required to take a *comprehensive* medical examination as a prerequisite for renewal of their permits.

Illinois took a major step in this direction with the recent passage by the 77th General Assembly of Senate Bill 1530. The bill, which ISMS endorsed, is designed to upgrade standards by requiring permit physicians to pass an examination administered by the Department of R&E for renewal of their permits after July 1, 1973.

Since the new law does not specify what type of examination permit physicians must pass, certain factions would defeat the intent of this law by requiring only a *superficial* exam.

In the interest of the public, ISMS recommends that permit physicians be required to pass the FLEX examination, or a comparable test, to continue practicing in Illinois hospitals.

X. FLEX Examination

At present, 41 states, including Illinois, require foreign medical graduates to pass the FLEX examination for licensure. The purposes of FLEX are:

A. To provide state medical examining committees with a high quality, uniform and valid examination for the purpose of evaluating clinical competence and qualifications for licensure;

B. To establish uniformity of examination between states; and

C. To create a rational basis for the management of the foreign medical graduate problem.

Since there are no effective procedures for evaluating foreign medical schools . . . and the graduates of these schools are only sketchily evaluated prior to their American training . . . FLEX provides the only effective evaluation of foreign medical graduates.

Arguments that the FLEX discourages the foreign graduate from practicing in Illinois are unfounded. For of the 15,299 physicians in Illinois January 1, 1971, some 4,542 were foreign medical graduates—almost 30 percent of the Illinois physician population!

This summer, a 65-year-old Illinois "permit physician," who graduated from Ludwig University in Germany in 1929, successfully completed the FLEX examination—evidence that FLEX is not as insurmountable as some factions claim.

Despite objections of many foreign graduates, ISMS recommends that Illinois continue to require foreign medical school graduates to pass the FLEX examination for licensure.

XI. American Graduates of Foreign Medical Schools

Over 36,000 students applied for admission into American medical schools this fall. Since there are only 14,000 places in the freshman class, some 22,000 students were refused admission. Even if only half of these applicants were qualified, it means that 11,000 qualified students were denied access because of our limited facilities.

While all Ilinois medical schools are to be commended for their expansion efforts of the past few years, the University of Illinois is to be especially commended for the establishment of its "medical schools without walls" in Rockford and Peoria. Unfortunately, this unique program has been threatened by drastic reductions in the university's requested budget.

As a result, Illinois' efforts to accommodate many of these 11,000 qualified students have been frustrated and they are forced to enroll in foreign medical schools.

If they could attend "First Rate" foreign schools, there would be no problem; however, the better foreign schools are interested primarily in training students from their own country . . . and take only a very small number of American students. Consequently the majority of our American students in foreign schools are receiving a second class medical education which is poor by even the most lenient American standards.

While recognizing the emotional appeal of these young people seeking an education denied them in their own country, we must realize that the Legislature and the Medical Examining Committee also have a responsibility to maintain high standards of health care for Illinois. No matter how great the emotional appeal, they cannot license inadequately trained people.

According to the American Medical Association, there have been four separate routes by which foreign medical graduates may enter American medical educational programs:

A. "Admission with advanced standing to American medical schools. A coordinated transfer system (COTRANS) has been established by the Association of American Medical Colleges in cooperation with the National Board of Medical Examiners to assist American citizens studying in foreign medical schools to make application to appropriate American medical schools.

B. Certification by ECFMG on the basis of satisfying the ECFMG educational requirements, as well as passing the ECFMG examination.

C. Obtaining a full and unrestricted license to practice medicine, issued by a state or other United States jurisdiction authorized to license physicians.

D. (Applicable only in California) U.S. citizens who pass the licensure examination in any state in which the law provides that a license to practice medicine in that state will be issued to the physician after satisfactory completion of his internship or residency in that state, without further examination. To be eligible for this route,

the foreign medical graduate must have completed all educational requirements that would make him eligible for ECFMG certification should he choose to apply."

The AMA recently approved a new or "fifth pathway" by which American students in foreign medical schools can enter American postgraduate medical educational programs. Briefly, it allows a graduate of an American pre-medical program—who has completed the formal portion of a foreign medical school—to become eligible for American internships and residencies by completing a "clinical clerkship" or "junior internship" under the aegis of an American medical school. This new program is now being offered by some 17 medical schools throughout the country. Unfortunately none of the Illinois schools has seen fit to offer such a program.

ISMS recommends that: (1) the General Assembly increase the budget allocation for Illinois medical schools to facilitate increased enrollment; and (2) a state-sponsored medical school in Illinois be directed to initiate the AMA's "fifth pathway" on a pilot basis.

XII. Certification of Allied Health Personnel

At a time when education and training of health professionals is undergoing rapid change and the functions of health workers are being expanded, it would be unwise to develop new statutes that define functions narrowly and that establish rigid requirements for education and training.

While we endorse the concept of innovation and experimentation in developing new categories of health manpower, ISMS concurs with Dr. Morton C. Creditor, Executive Director of the Illinois Regional Medical Program, who told this Commission on April 10, 1972, that:

"I do not think we should license physician's assistants, physician associates, Medex's, emergency care technicians, lab or X-ray technicians or nurse practitioners. On the other hand, we should promote in every way possible the education and utilization of these people.

Licensure should be limited to those categories of personnel who may, during the course of their careers, function autonomously thus assuming independent and ultimate responsibility for their actions. I do *not* envision these newer types (of health professionals) as functioning autonomously."

Neither does ISMS. That's why we recommend that *certification* of all emerging health professions be the prerogative of the most appropriate existing examining committee. For example, the control of physician's assistants, as well as the physicians utilizing such services, should be the responsibility of the Medical Examining Committee.

Note that we recommend certification, *not licensure.* We view licensure as the definition of a profession by statute and the legal requirement of all who practice that profession to meet certain minimal standards. Certification on the other hand, is the establishment of standards, based on either education or experience, to permit recognition of an individual as a member of a profession.

ISMS recommends that the current moratorium on licensure of additional health occupations be extended through 1975 . . . and that certification of emerging health professions be the prerogative of the most appropriate existing examining committee.

This would essentially be a request for holding action on licensure of additional manpower categories until long-range solutions are developed, and would not preclude amendment of existing licensure laws to permit expanded functions, authorize the functioning of new types of workers or increase access to licensure or certification for those with other than traditional prerequisites.

XIII. Increased Delegation of MD Tasks

Limitations in present credentialing mechanisms for health professions and occupations are generally acknowledged. Some of the shortcomings may be susceptible to immediate correction, which others may be only partially alleviated on a short-term basis through modification of present credentialing systems.

As a result, ISMS supports the recommendation of Dr. Creditor, who in his testimony before this commission on April 20th, said:

"Let us make sure the doctor's license and the Medical Practice Act permits him to delegate appropriate tasks to an assistant . . . without subjecting him to increased liability. This does not absolve him of ultimate responsibility, but gives him license as to how to exercise that responsibility."

ISMS recommends that the legislature remove barriers to increased delegation of tasks by physicians by amending the Medical Practice Act to read: "Nothing in this article shall be construed as to prohibit service rendered by a physician's trained assistant, a registered nurse or a licensed practical nurse if such service is rendered under the supervision, control and responsibility of a physician licensed to practice medicine in all of its branches and primarily engaged in the private clinical practice of medicine."

XIV. Institutional and Independent Practitioner Licensing

Nathan Hershey, LL.B. and others have proposed the concept of *state occupational licensure for independent practitioners* such as physicians, osteopaths, podiatrists and dentists, to whom the public has direct access, and institutional licensure to control health care personnel who work in an institution. Dependent practitioners such as nurses, practical nurses, physical therapists, medical technologists and so forth, would be unlicensed per se, but would be accountable to the employing institution or independent practitioner when working under their direction and supervision. The licensed institution or practitioner would be accountable in turn to a state agency for the quality of care provided and for the appropriate use of such manpower.

The Department of HEW recently funded the planning phase of a project to study the feasibility of credentialing health personnel by Illinois hospitals. The project—jointly sponsored by the Illinois State Medical Society, Illinois Hospital Association and Illinois Nurses Association —will involve hospitals downstate and in Chicago.

ISMS vigorously opposes the concept of institutional licensure of independent practitioners and registered nurses. Pending the results of the aforementioned pilot project, we also oppose institutional licensure for dependent practitioners.

XV. Upgrade Health Education Facilities

Protection of the health of all Illinois citizens is the responsibility of all of us. ISMS believes that the protection of the public can best be achieved by providing the best possible education for the health professionals trained in Illinois.

ISMS therefore recommends that the Health Care Licensure Commission support legislation requiring that all institutions of higher education which educate students in the health care field be accredited by an agency recognized by the U.S. Office of Education and the National Commission on Accrediting; and that all U.S. graduates in the health care fields who are applicants for licensure in Illinois be graduates of schools meeting these educational requirements.

XVI. Allied Health Career Mobility

ISMS believes that effective utilization of allied health manpower is unnecessarily limited by outmoded and restrictive licenses or statutes and by educational policies which obstruct career advancement.

These so-called "professional ceilings," which prevent vertical and lateral mobility, also tend to discourage people from seeking careers in allied health professions.

ISMS and the American Medical Association believe that "career ladder" training projects for health workers must be established on a broader scale, in arrangements between hospitals and vocational schools, colleges and professional schools.

Within each health profession, there should be potential for educational and occupational movement in a vertical fashion that might make it possible—based upon completion of educational requirements and measured capabilities—for an individual to move with comparative ease from one level to another, e.g., an orderly should be able to qualify by examination for a practical nurse . . . a practical nurse should be able to qualify by exam for a registered nurse . . . etc.

In addition to vertical movement, there should be provided an opportunity for horizontal or lateral transfer between professions. The importance of developing such educational and career pathways cannot be overemphasized if the need for increased comprehensive health services is to be met.

ISMS recommends that Illinois should amend its licensing laws, where feasible, to acknowledge equivalency testing as a means of determining one's eligibility to take a licensure examination . . . or enter an accredited program with advanced standing. ◄

Private Physician's Role in VD Control

(Continued from page 471)

The negative assumption about the ability of pubic health epidemiologists to maintain confidentiality may have been valid at one time, but it is not true today. First, the educational standards for public health workers are very high, most areas requiring a college degree; second, the epi workers are trained through a nationwide program that assures a measure of uniformity in approach. Finally, their training emphasizes ways and means of assuring confidentiality in a wide range of circumstances provided by years of previous epidemiologic experience. This is not to say that a break in confidentiality cannot occur. It only indicates that the vast majority of epi workers are able to successfully complete an entire contact investigation with professionalism that benefits the doctor, his patient, and public health in general.

The last major point that physicians often do their own epidemiology presents a number of problems. First, the physician may have personal prejudices about certain types of sexual behavior that may prevent him from asking his patient necessary and pertinent questions. Second, the physician often knows his patient outside the office and thus feels awkward about delving into his private life. Third, the patient often feels reticent about discussing these matters with his doctor for fear of losing self esteem. Finally, and most important, the physician simply does not have the time to effectively reach and persuade all the people potentially involved in the chain of infection.

With VD rates climbing at 10-15% a year, it is time for each physician to re-evaluate his position on reporting, and ask if the reasons he holds for not reporting are as valid as they once may have been. It has been shown that once a doctor has seen effective epi work in his own practice, his fears about reporting are replaced by confidence in the validity of aiding in breaking the chain. Public and private health need each other to control venereal diseases and the public deserves our mutual cooperation.

Murray C. Brown, M.D.
City of Chicago Health Commissioner

Happy Thanksgiving

Skin Saver



Alpha-Keri®

therapeutic bath oil

locks in moisture

relieves dry, itchy skin with the first bath or shower.

See PDR. Supplied: 8 and 16 fl. oz. bottles; 5 oz. aerosols.

WESTWOOD PHARMACEUTICALS INC. Buffalo, New York 14213

Send samples of Alpha-Keri bath oil.

DR. _____

ADDRESS _____

CITY STATE ZIP 7

investment corner

The 50% Maximum Tax on Earned Income

By Vincent L. Lanuza, Jr. and Joseph A. Bailey, Jr.
Peat, Marwick, Mitchell & Co.
111 West Monroe Street, Chicago, 60603

In the past, an individual's earned income was subject to the same graduated Federal income tax rates as other ordinary income. Because of the high income tax rates and the resulting large income tax bills, some individuals invested in "tax avoidance devices," such as oil and gas, or real estate, which sheltered their income and deferred and/or reduced their income tax liability.

Congress felt that the upper graduated income tax rates encouraged taxpayers to seek out the "tax avoidance devices," so-called "tax loopholes," and concluded that one of the most effective ways to prevent their development and use was to reduce the incentive for engaging in such activities by reducing the high tax rates on earned income. As a result, the Tax Reform Act of 1969 added a new provision, Section 1348, to the Internal Revenue Code. This revolutionary section entitled "Fifty Per Cent Maximum Rate on Earned Income" provides, under certain conditions and with some modifications, a maximum tax rate of 50% on the earned income of an individual.

"Earned income" includes wages, salaries, professional fees, and compensation for personal services. In the case of a trade or business (other than in corporate form) where both personal services and capital are material income producing factors, a reasonable amount is considered compensation for personal services rendered by an individual, but it cannot exceed 30% of his share of the net profits from such trade or business. When gross income of the business consists principally of fees, commissions, or other compensation for personal services performed by an individual who is personally responsible for those services, capital is not a material income producing factor and the 30% rule does not apply. Thus, income from the professional practice of a doctor, dentist, or technician would qualify as "earned income" for maximum tax rate purposes; although the practitioner may have a substantial capital investment in professional equipment, his capital investment is regarded only as incidental to his professional practice.

To qualify for the maximum tax rate of 50% on earned income, an individual cannot use income averaging, or, if married, file a separate return. As the effective tax rate on other sources of income is not affected by the maximum earned income tax rate, it is generally desirable to compute tax under both alternatives if it appears that income averaging may be beneficial.

In order to enjoy any tax savings at all under Section 1348 after 1971, a married individual filing a joint return will have to have earned taxable income in excess of $52,000 and a single individual will have to have earned taxable income in excess of $38,000.

The following hypothetical illustration indicates the amount of Federal income tax saved in calendar year 1972 for a doctor filing a joint return with the following income and deductions:

(Continued on page 521)

PULSE ●●● of the doctor's wife

Mrs. Robert Hart, Pulse Editor

From the President's Desk . . .

We are in the midst of our Board and District meetings. The State Auxiliary has distinguished itself as an organization assisting the Illinois State Medical Society by conducting programs to preserve the health and safety of the people. Our major areas of concern continue from year to year, with the State Auxiliary providing general information, suggesting priority projects, and preparing educational material to assist the county leaders in working in these areas.

The state chairmen have reconstructed and broadened their programs. These Health Education and Volunteer Services can be activated depending upon the needs of the community, keeping in mind the National Auxiliary is emphasizing Nutrition and Safety. Programs developed by the county auxiliaries should have goals, a working force, and a completion date, thus assuring the feeling of accomplishment to the members and citizens participating.

It is also important to define health so we know what we are doing. "Health is a state of optimum physical, mental, and social well-being and not merely the absence of disease or infirmity." Health is a condition in which the individual is able to mobilize all of his resources—intellectual, emotional, and physical—for best living.

Remember, too, a leader who gets results studies and correctly uses parliamentary procedure. Ladies sometimes feel parliamentary law is too formal. Experience has shown that a knowledge of it is one of the most assuring assets that members of an organization can possess. It is the accepted system of rules for conducting business, preserving order, and governing debate in meetings. Its purpose is the fair and orderly coverage of the business with speed and efficiency. It is the code of ethics for working together.

I'll leave you to ponder some ideas in the hope it will affect your attitudes and actions as we prepare for our varied activities:

Broaden your vision
Communicate
Listen
Keep learning
Be yourself
Give as you would get
Show courage
Don't jump to conclusions
Take time to think
Don't be in such a hurry
and . . .
Say "Thanks."

Mrs. August Martinucci
President ◄



practice management

BE YOUR OWN TAX COLLECTOR

By Richard B. Currie
Senior Consultant of Professional Business Management
The 400 Center, 400 County Line Road, Deerfield, 60015

During World War II, our government, needing more money than ever before in its history, decided to increase personal income taxes. Many thousands of workers who had never before been subject to income tax, because of the modest nature of their wages, found that they would have to pay large amounts, or else.

The government, in its wisdom, recognizing that Mr. Average Wage-earner would not have anything left to pay his tax with if something was not done to help, invented the Withholding Tax. Charts were created, and every paycheck was whittled down to cover the tax. The employer, with his charts became the tax collector, thus saving Mr. Average Wage-earner from ruinous insolvency.

However, the government did not invent any such vehicle for the self-employed and most physicians are self-employed. The only concession made was to ask the physician to pay his taxes on a quarterly basis.

Over the years, this has worked out fairly well. Most doctors manage to pay their quarterly taxes, but not always without stress. Wouldn't it be better to have a self-imposed withholding tax? The method can be quite simple and even painless.

In any well organized medical practice, all of the receipts from patients are deposited periodically in a business checking account. This may be done daily or weekly or, in some cases, monthly. The bills, including tax payments are paid out of this account. One of the drawbacks is that the money in such an account is easily accessible. This may seem to some to be advantageous, but it can be a trap when things get tight. The salaried individual never sees the taxes that are withheld from his paycheck. Why should you be tempted by their presence.

The married doctor who takes in $66,000 in gross receipts will pay about $10,000 in Income Tax, depending on his personal deductions and exemptions. That represents 15.2% of his receipts. No matter how big his checkbook balance looks, he must realize that 15.2% of his deposits are going to Uncle Sam, no matter what.

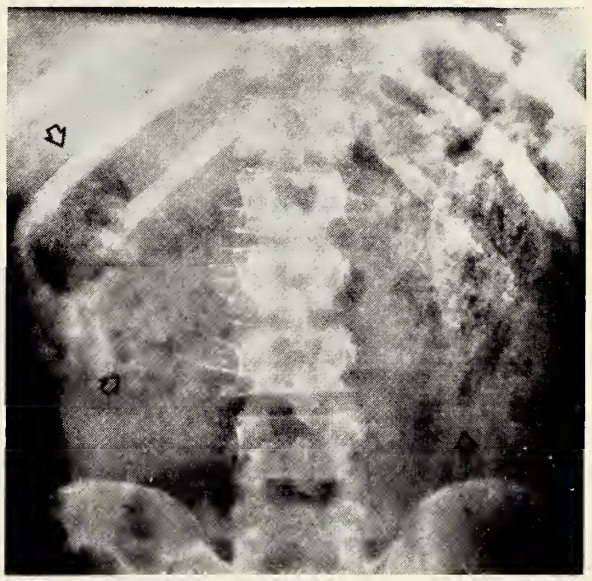
What could be easier than to write a check equal to 15.2% (or round it off) of each deposit and put it into a savings account? Your accountant calls that an *Escrow Account*. Call it anything you like, it does not get into the easily accessible checking account to tempt you. Then, when the quarterly tax payment comes due, it can be transferred back to your business account and paid out to the "man."

Why not look at your last Income Tax and your gross receipts for that year and see what percent is going as tax? It has to be paid, so you might as well make it easy. ◄

the view box

Leon Love, M.D./Chairman/Department of Radiology
Loyola University Stritch School of Medicine

This patient is a 38-year-old male who had a history of repeated bouts of alcoholism and had a previous cholecystectomy. Physical findings revealed a temperature of 104°F with diffuse tenderness over the upper abdomen.



What's your diagnosis?

1. Pneumatosis intestinalis
2. Emphysematous pancreatitis
3. Gas producing perinephric abscess
4. Liposarcoma

(Answer on page 531)

Twenty-Four Crippled Children Clinics Slated for December

Twenty-four clinics for Illinois' physically handicapped children have been scheduled for December by the University of Illinois, Division of Services for Crippled Children. The Division will count seventeen general clinics providing diagnostic orthopedic, pediatric, speech and hearing examination along with medical social, nursing services. There will be five special clinics for children with cardiac conditions, and two for children with cerebral palsy. Any private physician may refer to or bring to a convenient clinic any child or children for whom he may want examination or consultative services.

December 5 Belleville—St. Elizabeth's Hospital
December 6 Carmi—Carmi Township Hospital
December 6 Hinsdale—Hinsdale Sanitarium
December 6 Rock Island Cerebral Palsy—Foundation for Crippled Children and Adults
December 7 Sterling—Sterling Community Hospital
December 7 Lake County Cardiac—Victory Memorial Hospital
December 7 Springfield—St. John's Hospital
December 7 Effingham—St. Anthony's Memorial Hospital
December 8 Chicago Heights Cardiac—St. James Hospital
December 12 Peoria—St. Francis Hospital
December 12 E. St. Louis—Christian Welfare Hospital
December 13 Springfield Pediatric Neurological—Diocesan Center
December 13 Champaign-Urbana—McKinley Hospital
December 13 Aurora—St. Joseph Mercy Hospital
December 14 Bloomington—Mennonite Hospital
December 14 Litchfield—St. Francis Hospital
December 18 Peoria Cardiac—St. Francis Hospital
December 19 Rock Island Area General—Moline Public Hospital
December 19 Peoria—St. Francis Hospital
December 20 Chicago Heights—St. James Hospital

(Continued on page 523)



new pharmaceutical specialties

by paul dehaen

For detailed information regarding indications, dosage, contraindications and adverse reactions; refer to the manufacturer's package insert or brochure.
Single Chemicals: Drugs not previously known, including new salts.
Duplicate Single Products: Drugs marketed by more than one manufacturer.
Combination Products: Drugs consisting of two or more active ingredients.
New Dosage Forms: Of a previously introduced product.

The following new drugs have been marketed:

DUPLICATE SINGLE PRODUCTS

PRESAMINE Psychostimulant ℞
Manufacturer: USV Pharmaceuticals
Nonproprietary Name: Imipramine HCl
Indications: Symptoms of depression; endogenous depression more likely to respond.
Contraindications: Concomitant use of MAOI drugs; hyperpyretic crisis or severe convulsive seizures; during recovery from myocardial infarction.
Warnings and Precautions: Follow package insert.
Dosage: Gradually increasing doses as per instructions.
Supplied: Tablets, 10, 25 and 50 mg.

UTRASOL Sulfonamide ℞
Manufacturer: Conal
Nonproprietary Name: Sulfamethizole
Indications: Susceptible urinary tract infections.
Contraindications: Hypersensitivity to sulfonamides, infants less than two months of age and pregnancy at term.
Precautions: Use with caution in impaired renal and hepatic function, severe allergy and bronchial asthma.
Dosage: Children and adults—30 to 45 mg./kg./24 hours, divided into four doses.
Supplied: Tablets, 500 mg.

STATOBEX Antiobesity ℞
Manufacturer: Lemmon
Nonproprietary Name: Phendimetrazine Tartrate
Indications: Short term anorexigenic agent as adjunct to restricted diets in simple exogenous obesity.
Contraindications: Cardiovascular disturbances; 14 days after use of MAOI.
Precautions: Not to be used in children under 12 years.
Dosage: Tablets, 35 mg.

COMBINATION PRODUCTS

FEMININS Vitamins and Minerals o-t-c
Manufacturer: Mead Johnson
Composition:

Vitamin A	U.S.P. Units	5000
Vitamin D	U.S.P. Units	400
Vitamin E	Int. Units	10
Vitamin C	(ascorbic acid)	200 mg.
Vitamin B_1	(thiamin)	1.5 mg.
Vitamin B_2	(riboflavin)	3 mg.
Vitamin B_6	(pyridoxine)	25 mg.
Vitamin B_{12}		10 mcg.
Niacin		15 mg.
Folic acid		0.1 mg.
Pantothenic acid		10 mg.
Iron		18 mg.
Zinc		10 mg.

Indications: Vitamin and mineral therapy in conjunction with oral contraceptives.
Dosage: One tablet daily.
Supplied: Tablets

ORNACOL Cough and Cold Preparations o-t-c
Manufacturer: Smith Kline & French
Composition: Dextromethrophan hydrobromide 30 mg.
Phenylpropanolamine hydrochloride 25 mg.
Indications: Temporary relief from coughing and nasal congestion associated with the common cold and sinusitis.
Precautions: Use with caution in hypertension, heart disease, thyroid disease, or diabetes; avoid MAO inhibitors.
Dosage: Adults and children over 12—one capsule four times daily.
Supplied: Capsules

ORNACOL Cough and Cold Preparations o-t-c
Manufacturer: Smith Kline & French
Composition: Each 5 cc. (teaspoonful) contains:
Dextromethorphane hydrobromide 15 mg.
Phenylpropanolamine hydrochloride 12.5 mg.

(Continued on page 531)

Doctor's News

SUPPORT BLOOD DRIVES—Due to the Blood Labeling Law that went in effect October 1, 1972, there has been much concern about a blood shortage in Illinois. Many organizations and offices are setting up blood drives. Physicians are urged to encourage their patients, friends and community to participate in area blood drives or to donate blood through a local blood bank.

DOWNSTATE VISITATION PROGRAM DEVELOPED—Illinois State Medical Society and a committee on Family Practice of the Medical Student Council from the University of Illinois College of Medicine have jointly developed a concept of a selective nonstructured several day visitation program. This will bring medical students and downstate host physicians and hospitals together to accomplish a series of specific activities and objectives: 1) to acquaint some Illinois physicians and hospital staffs with the attitudes, goals and interests of some of today's junior and senior medical students in Illinois; 2) to acquaint some medical students from Illinois medical schools with the attitudes and interests of Illinois physicians and hospital staffs regarding health care delivery; and 3) to study the development of a permanent on going relationship between Illinois medical students and Illinois physicians and hospital staffs.

Physicians in LaSalle and Adams counties have shown interest in the program and a pilot program is being set up. Guidelines are being distributed to the students and interested physicians.

IMPLIED CONSENT LAW DOES NOT REQUIRE HOSPITAL BLOOD TESTS—Illinois' new Implied Consent Law became effective October 1. When police suspect that car drivers involved in accidents are drunk, they may demand that such drivers submit to alcohol breathalizer tests, usually performed at police stations. If drivers refuse, they may lose their licenses. However, drivers are entitled to demand an additional test of their choice, such as the more precise blood alcohol test performed at a hospital or clinical lab.

Hospitals, therefore, may expect requests for blood alcohol tests by drivers and sometimes by police; but according to Harry L. Kinser, legal counsel for the Illinois Hospital Association, the Implied Consent Law does not require hospitals to make blood alcohol tests upon demand of drivers or police.

PROJECT "COPE" STARTED AT LOYOLA—The Loyola University Hospital administration and the Department of Obstetrics outpatient center have developed a new system to slash the costs of childbirth for young couples of middle-income—Project C.O.P.E. or Comprehensive Obstetrics and Programmed Economy.

"The new project was designed to 'cope' with the needs of young couples who need obstetric care and who can pay for part of their obstetric costs but have inadequate health insurance. It is not a welfare program, and is not meant to replace public health programs," states James A. O'Leary, M.D., professor and chairman of Obstetrics-Gynecology at Loyola University Stritch School of Medicine.

"Under this new program, costs will be reduced 50-75% by minimal hospitalization period (usually the patient will go home on the second postpartum day) and by decreasing delivery room charges by 20%," said Dr. O'Leary. All patients will be treated as private patients by licensed physicians.

RULING ON RUBELLA TESTING LAW—As of October 1, 1972, a new law would have required that every woman applying for a marriage license in Illinois be tested for immunity to rubella; exempted from this law were women objecting on religious grounds. Each county clerk was to receive an affidavit signed by a physician indicating he had performed or ordered the HI test. In addition, the regulation required a physician to counsel the woman regarding the test.

Exception to this law was taken by many physicians and organizations since there was no necessity for testing all women, and because those already married would not be tested. There was no quarrel with the intent of the law for the prevention of birth defects. However, due to specific deficiencies in the act, the desired effect was obtained at the expense of many.

A series of hearings was held in the Circuit Court of Cook County. As a result, a temporary injunction has been issued enjoining the state and the county clerks from implementing the Rubella Testing Law. Physicians, therefore, need not file an affidavit in any Illinois county. Some county clerks are not aware of this injunction and physicians should inform their patients that if a marriage license is denied on this basis, the patient should appeal to the local county state's attorney.

Amendatory legislation may be introduced in the next session of the Illinois General Assembly.

PUBLIC HEALTH DEPARTMENT CAN EMBARGO DANGEROUS TOYS—As of October 1, the Illinois Department of Public Health has the authority to embargo toys which may be dangerous to children, according to Dr. Franklin D. Yoder, Director. The Illinois program will be based on two areas of concern: (1) any banned toys on the federal level will be investigated by the department and then banned in Illinois; (2) the department will handle complaints involving potentially dangerous toys.

GALESBURG COTTAGE HOSPITAL JOINS RUSH MEDICAL CENTER—The fifth hospital to join with Rush-Presbyterian-St. Luke's Medical Center is Galesburg Cottage Hospital, Galesburg. The other hospitals affiliated include Christ Community Hospital, Oak Lawn; Community Memorial General Hospital LaGrange; Swedish Covenant Hospital, Chicago and West Suburban Hospital, Oak Park.

TRAUMA CENTER DEDICATION IN PEORIA—Dedication ceremonies for the regional trauma center at St. Francis Hospital, Peoria were held October 11. Elliott Richardson, U.S. Secretary of Health Education and Welfare and Mrs. Richard B. Ogilvie were special guests at the dedication.

FAIRVIEW HOSPITAL HAS A NEW NAME—Chicago Lakeshore Hospital is the name for the private psychiatric facility previously known as Fairview Hospital, located at 4840 Marine Drive, Chicago. Management of Chicago Lakeshore Hospital includes Ray Stevenson, regional vice president; Roy Kaye, administrator; J. Herbert Maltz, M.D., medical director; Ronald Lathovwers, controller; Margaret Upp, R.N., M.N.A., director of nursing; and Marshall Gavin, assistant administrator.

PHYSICIANS IN THE NEWS—**Lionel Cohen, M.D.**, has been named chairman, Department of Radiation Therapy at Michael Reese Hospital and Medical Center, Chicago. **Edmund M. Collins, M.D., D.D.S.**, of the Christie Clinic, Champaign, has been elected to serve on the Board of Trustees of the American Association of Medical Clinics. Schwab Rehabilitation Hospital, Chicago appointed **Gloria L. Leviton, Ph.D.**, as Director of the Psychology Department.

Donald F. Steiner, M.D., the discoverer of proinsulin, has been named as acting chairman of the Department of Biochemistry at the University of Chicago. New appointments at the University of Chicago include **Iracema M. Baccarini, M.D., M.S., Ph.D.**, as associate professor in the Department of Obstetrics and Gynecology and the Department of Pathology; and **Chase P. Kimball, M.D.**, as associate professor in the Departments of Psychiatry and Medicine.

Leta McKinney, Ph.D., a professor of health care planning at Southern Illinois University School of Medicine, Springfield, has been appointed to serve as an associate coordinator for Bi-State (Illinois & Missouri) RMP.

Illinois Physicians elected as Governors of the American College of Surgeons include: **Charles E. Baldree, Jr.**, Belleville; **T. Howard Clarke**, Chicago; **Ward H. Eastman**, Peoria; **John H. Issacs**, Skokie; **William A. Larmon**, Chicago; **Thomas W. McElin**, Evanston; **Edward F. Scanlon**, Evanston and **Burton J. Soboroff**, Chicago.

Carl Steinhoff, M.D. Honored



Carl Steinhoff, M.D., Skokie, (center) was honored at the ISMS Leadership Conference October 29, for his 22 years of devotion as chairman of the Illinois Medical Advisory Committee to the Selective Service System. He will be replaced on the committee by Frank J. Jirka, Jr., M.D. president of ISMS. Daniel Cronin, representative from the National Selective Service System and Lt. Col. Robert Brittin, representative of the Illinois Selective Service System presented Dr. Steinhoff with a certificate and medal for exceptional service. Pictured with Dr. Steinhoff are (left to right): Cronin, Mrs. Lois Bush, daughter of Dr. Steinhoff; Dr. Steinhoff; Dr. Jirka and Lt. Col. Brittin.



David R. Boyd, M.D.

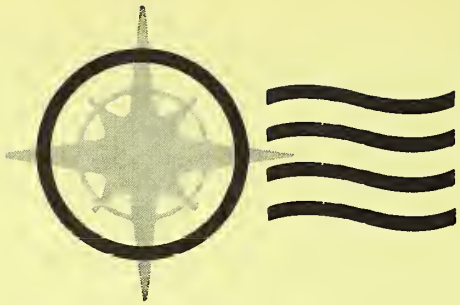
Dr. Boyd Recipient of Lambert Award

David R. Boyd, M.D.C.M., recently received a Gerard B. Lambert Award for his development of a computerized Trauma Registry of accident information and diagnostic findings which links the state's trauma centers, hospitals and physicians. The Lambert Award winners are judges on the innovative and imaginative ideas which improve patient care and reduce health costs. Dr. Boyd, chief of the division of emergency medical services and highway safety, and Bruce Flashner, M.D., developed the Governor's Trauma Plan for improved care for accident victims in Illinois.



ISMS Awards Two Grants

Willard C. Scrivner, M.D., ISMS president-elect, presented ASPIRA, Inc., and Bio Medical Careers each a $5,000 grant on behalf of ISMS, at the Leadership Conference held October 29. These grants are for the purpose of recruiting minority people in health careers. In attendance at the Leadership Conference are from (left to right): Dr. Scrivner; Wali Siddiq, representative for Bio-Medical Careers; Mrs. Silvia Fox, representative for ASPIRA, Inc.; and Morgan Meyer, M.D., Chairman, ISMS Manpower Committee.



membership forum

October 13, 1972

Willard C. Scrivner, M.D.
President-Elect
Illinois State Medical Society
360 North Michigan Avenue
Chicago, Illinois

Dear Doctor Scrivner:

In accordance with our previous discussion I am enclosing copies of a proposed revision in the billing form (DPA-132) for physicians providing services to public assistance recipients.

As I indicated to you, I trust that the Board will not judge the form either as to the final printing layout or size but be more primarily interested in the method of the physician indicating the services provided by him in a precoded format. The final format will be more professionally done and insofar as possible be accommodated on an 8½ x 11 size form. **The primary purpose is to provide a format which will allow the physician to indicate in better than 90% of the services billed to the Department only the following information: date of service, place of service, and charge.**

I think it also advisable to indicate some concern that the Department has in the precoded format. One of these concerns is the fact that a physician might limit himself to the preprinted codes which may not be specific enough to give exact descriptions of procedures provided, and as a result not receive the appropriate payment for those services.

We have attempted to structure the form in a manner similar to the AMA approved health insurance claim form. By this statement we are attempting to indicate that we would not ask for any information which is not routinely requested on that billing format.

We did discuss the possibility of the Department preprinting forms and making these available to physicians upon request. The preprinting of the form would follow very much the pattern of Blue Shield and other insurance carriers in that it would provide the physician's name, address and any other type of identifying code numbers being shown without any additional effort on the part of the physician.

We believe this can be accommodated and are willing to proceed with this by giving a general release to the practitioners indicating this service would be available and requesting them to provide us with the proper identifying information they wish to have shown on the form. This, of course, would include the name, mailing address, identifying numbers, etc.

The Department has discussed in considerable detail the possibility of providing a total coding operation to be done by staff in this office. We feel that this is a very unsatisfactory procedure in a number of ways which would work to the detriment of the practitioners as well as create a considerable, additional administrative expense. We are currently receiving in excess of 225,000 individual physician claim forms per month. We feel that any attempt to provide extensive coding in this office not only gives cause for concern of improper coding and additional administrative expense, but might result in an additional payment delay which we feel at this time would be completely unacceptable both to the providers and the Department.

In speaking to the length of time from receipt of bill to payment, as I indicated and as Director Weaver and the Governor's office have also mentioned, the Department is in the process of a total systems redesign effort and are hopeful of within a very short period of time reaching a *30-day payment return.* We were at one time able to accomplish this; unfortunately it was a very short-lived payment cycle largely due to the increased volume of recipient caseloads and the corresponding increases in the number of bills processed. The Department is currently processing 1,500,000 individual claims per month and unfortunately the payment cycle is generally in excess of 35 days.

Again, I would like to express my appreciation for your efforts in this endeavor and restate the Department's willingness to work with the Society in anyway that is mutually beneficial.

Very truly yours,
ROBERT G. WESSEL, Chief
Division of Medical Services
Department of Public Aid

A·H·ROBINS

For the patient with a terminal illness, PAIN past, present, and future can dominate his thoughts until it becomes almost an obsession. The more he is aware of the pain he is now experiencing, the more difficult it is to erase his memory of yesterday's pain, and to allay his fearful anticipation of tomorrow's pain. Surely the last thing this patient needs is an analgesic containing caffeine to stimulate the senses and heighten pain awareness. A far more logical choice is Phenaphen with Codeine. The sensible formula provides ¼ grain of phenobarbital to take the nervous "edge" off, so the rest of the formula can help control the pain more effectively. Don't you agree, Doctor, that psychic distress is an important factor in most of your terminal and long-term convalescent patients?

the analgesic formula that calms instead of caffeinates

Phenaphen® with Codeine

Phenaphen with Codeine No. 2, 3, or 4 contains: Phenobarbital (¼ gr.), 16.2 mg. (warning: may be habit forming); Aspirin (2½ gr.), 162.0 mg.; Phenacetin (3 gr.), 194.0 mg.; Codeine phosphate, ¼ gr. (No. 2), ½ gr. (No. 3) or 1 gr. (No. 4) (warning: may be habit forming).

Indications: Provides relief in severer grades of pain, on low codeine dosage, with minimal possibility of side effects. Its use frequently makes unnecessary the use of addicting narcotics. **Contraindications:** Hypersensitivity to any of the components. **Precautions:** As with all phenacetin-containing products, excessive or prolonged use should be avoided. **Side effects:** Side effects are uncommon although nausea, constipation and drowsiness may occur. **Dosage:** Phenaphen No. 2 and No. 3—1 or 2 capsules every 3 to 4 hours as needed; Phenaphen No. 4—1 capsule every 3 to 4 hours as needed. For further details see product literature.

(III) Phenaphen with Codeine is now classified in Schedule III, Controlled Substances Act of 1970. Available on written or oral prescription and may be refilled 5 times within 6 months, unless restricted by state law.

A. H. Robins Company, Richmond, Virginia

Investment Corner

(Continued from page 506)

Earned net income (Fees for personal services, net of related expenses)	$ 200,000
Other income (including $36,000 of tax preferences)	50,000
Adjusted gross income	250,000
Itemized deductions and exemptions	30,000
Taxable income	$ 220,000

Earned taxable income ($200,000 ÷ $250,000 × $220,000) − ($36,000 − $30,000) = $170,000.

Tax computed without the maximum tax	$ 124,980
Tax computed using maximum tax	111,660
Tax savings	$ 13,320

The amount of an individual's earned taxable income in proportion to his other income (or losses), his tax preference amounts, and his itemized deductions will determine his tax savings with the new maximum tax limitation on earned income. If an individual can control these items during the year, he may be wise to discuss them with his tax advisor promptly. Significant tax savings may result from a little advance planning. ◄

EKG of the month

(Continued from page 472)

Answers:

1B and C; 2A and C. In this patient the ECG was not initially diagnostic. Junctional tachycardia was suspected because no P waves could be seen, and the QRS morphology was supraventricular in type. However, the examination of the jugular venous pulse showed distinct A and V waves. Auscultation demonstrated that the A wave preceded the first heart sound. There appeared to be a large gap between the A and V waves. This suggested that first degree AV block was present, and the P wave was buried in the T wave of the preceding beat. Digitalis was withheld and the PR interval gradually shortened toward normal. Withdrawal of digitalis would be recommended in marked first degree AV block as well as junctional tachycardia. For further information on the jugular venous pulse in arrhythmias, see Morton E. Tavel's *Clinical Phonocardiography and External Pulse Recording.* ◄

what goes on

a guide to continuing education

November 26-29—American Medical Association

26th Clinical Convention

Contact: AMA, 535 North Dearborn, Chicago, IL

Netherland-Hilton Hotel, Cincinnati, OH

November 27-December 2—J. Lloyd Johnson Associates

Laboratory Management Workshop

One day of lectures, followed by six workshops with maximum enrollment of 17 participants per workshop session, is planned to provide the maximum transfer and exchange of knowledge utilizing a practical rather than theoretical framework. Case study materials of actual clinical laboratory management problems and role playing assignments are two of the techniques to be used in the workshop sessions to insure maximum participation in each workshop.

Topics will include cost accounting, human relations (objectives, goals, plans), financial analysis, workload programming, salary administration, evaluation of laboratory services, and participative management. In addition to the workshops and lectures, dinner speakers will cover topics such as "Satisfying the Attending Physician," "Learning to Live with Third Parties," "Is Centralization the Answer?," etc.

Contact: J. Feigon, J. Lloyd Associates, 1500 Skokie Bldg. Northbrook, IL 60062

University of Chicago Center for Continuing Education

December 1-3, 5-7—Institute for Comprehensive Medicine

Management of Sexual and Marital Inadequacy—Seminar

An interdisciplinary approach for the management of sexual dysfunctions will be discussed. Topics covered will include: Psychology & Physiology of Sexual Response; Adolescent & Geriatric Sexual Problems; Behavior Modification, Biofeedback Control Therapy in Sexual Inadequacy" Compatible Divorce; Transsexualism; Sexual Variants & Fetishisms; Urologic Disorders; Management of Effective Orgasmic Response and other subjects.

Contact: Institute for Comprehensive Medicine, 9735 Wilshire Blvd., Beverly Hills, CA 90212

December 2-7—American Academy of Dermatology

The 31st Annual Meeting

This will feature special courses in various aspects of diagnosis and treatment of skin diseases, symposia, seminars-in-depth, special lectures and more than 125 informal discussion groups on selected subjects.

Contact: Stephen T. Donohue, 420 Lexington Avenue, Suite 443, New York, NY 10017

American Hotel in Bal Harbour

December 4-7—University of Texas

Cardiology Symposium

This program will present an intensive review in cardiology. The guest lecturer will be S. Gilbert Blount, Jr., M.D., Professor of Medicine; Division of Cardiology, University of Colorado Medical School, Denver, Colorado.

Contact: The office of the Dean, University of Texas, Graduate School of Biomedical Sciences at Houston, Division of Continuing Education, P.O. Box 20367, Houston, Texas 77025.

December 7—Illinois State Medical Society

7th Illinois Conference on School Health

The conference will be equally cosponsored by the Illinois Department of Public Health, Office of the Superintendent of Public Instruction and the Illinois State Dental Society.

The featured speaker will be John Sinocore, Ed.D., Special Assistant to the Commissioner for Health Education, New York.

Registration Fee: $4.00

Contact: Mr. Tom Janeway, Office of the Superintendent of Public Instruction, 316 South Second St., Springfield, IL 62706

Holiday Inn East, Springfield

December 15-16—University of Kentucky

Pediatric Ophthalmology Conference

Some subjects to the discussed are: Rapid Method for Retinoscopy, Decision-Making in Strabismus and Amblyopia, Conjunctive Bands Restrictive, Aminocentesis and Biochemical Tests, Microphthalmia: Should the eye be removed? Intraocular Inflammation: Apart from Steriods, what? Retrolental Fibroplasia.
Registration: $75.00 for practitioners, $10.00 for residents and fellows
Contact: Frank R. Lemon, M.D., Associate Dean for Continuing Education, College of Medicine, University of Kentucky, Lexington, Kentucky 40506

January 14-18—National Institute of Mental Health

Business Administration program for individuals in drug program administration.

Material covered will include funding mechanisms, grants and contracts, staffing, community organization, prevention and education, concepts in program planning, business law, comprehensive health care delivery systems, special operational and managerial problems and program evaluation.
Lecturers represent NIMH grants and contracts management personnel, administrative staff of major private and state comprehensive programs, and business management consultants.
No fee.
Contact: Drug Training Program, Center for Urban and Regional Studies, University of Miami, P.O. Box 8002, Coral Gables, Florida ◄

Clinics for Crippled Children

(Continued from page 509)

December 21 Elmhurst Cardiac—Memorial Hospital of DuPage County
December 21 Rockford—Rockford Memorial Hospital
December 22 Chicago Heights Cardiac—St. James Hospital
December 22 Evanston—St. Francis Hospital

The Division of Services for Crippled Children is the official state agency established to provide medical, surgical, corrective and other services and facilities for diagnosis, hospitalization and after-care for children with crippling conditions or who are suffering from conditions that may lead to crippling.

In carrying on its program, the Division works cooperatively with local medical societies, hospitals, the Illinois Children's Hospital-School, civic and fraternal clubs, visiting nurse association, local social and welfare agencies, local chapters of the National Foundation and other interested groups. In all cases the work of the Division is intended to extend and supplement, not supplant activities of other agencies, either public or private, state or local, carried on in behalf of crippled children. ◄



"Sorry, Sire, but 'Dicarbosil' hasn't been invented yet."

Dicarbosil®
ANTACID
Write for Clinical Samples
ARCH LABORATORIES
319 South Fourth Street, St. Louis, Missouri 63102

COOK COUNTY
Graduate School of Medicine
CONTINUING EDUCATION COURSES
STARTING DATES—1972-73

SPECIALTY REVIEW COURSE IN SURGERY, Part II, November 27
SPECIALTY REVIEW COURSE IN PEDIATRICS, April 2
SURGERY OF TRAUMA, Four Days, December 11
SYMPOSIUM ON SHOCK, Two Days, December 15
PROCTOSCOPY, SIGMOIDOSCOPY & FIBEROPTIC COLONOSCOPY, Three Days, December 11
MANAGEMENT OF COMPLICATIONS IN SURGERY, Four Days, March 6
PRE & POSTOPERATIVE CARE OF PATIENTS, Four Days, March 13
BLOOD VESSEL SURGERY, One Week, March 26
ADVANCES IN OBSTETRICS & GYNECOLOGY, One Week, November 13
BASIC OBSTETRICS, One Week, November 27
BASIC GYNECOLOGY, One Week, December 4
VAGINAL APPROACH TO PELVIC SURGERY, One Week, December 11
ADVANCES IN MEDICINE, One Week, November 27
GENERAL PEDIATRICS, One Week, November 27
ACUTE CARDIAC CARE, Three Days, December 5
BASIC ELECTROCARDIOGRAPHY, One Week, March 5
BASIC INTERNAL MEDICINE, One Week, March 19
REVIEW COURSE IN PSYCHIATRY, One Week November 13
INHALATION & REGIONAL ANESTHESIA, Request Dates

Information concerning numerous other continuation courses available upon request.

Address:

REGISTRAR, 707 South Wood Street,
Chicago, Illinois 60612

ANOTHER ISMS MEMBERSHIP PRIVILEGE
LOW-COST GROUP INSURANCE

GROUP DISABILITY PLAN

- **NEW**—Guaranteed renewable feature
- Sickness benefits to age 65
- Up to $250.00 weekly benefits

(PROTECT YOUR INCOME AND SECURITY)

GROUP SUPER MAJOR MEDICAL PLAN

- Up to $50.00 daily room and board
- Up to $25,000 for each accident or sickness
- In hospital and out of hospital expenses

(TRULY CATASTROPHIC PROTECTION)

FOR INFORMATION, ASSISTANCE & DETAILS CONTACT:

Administrators:

PARKER, ALESHIRE & COMPANY
ESTABLISHED 1901
Insurance

9933 N. Lawler Avenue
Skokie, Illinois 60076
Phone: 312-679-1000

Koenig & Strey
REALTORS

NEW ISSUE

This advertisement is neither an offer to sell nor a solicitation of an offer to buy any of these securities. The offering is made only by the Offering Circular to bona fide residents of the State of Illinois.

JULY 24, 1972

$500,000

THE KOENIG & STREY LIMITED PARTNERSHIP FUND

Limited Partnership Interests

A real estate tax-shelter investment partnership managed by Koenig & Strey Investment Properties, Inc.

PRICE $500 PER LIMITED PARTNERSHIP INTEREST
Minimum purchase is ten limited partnership interests
($5,000)

Copies of the Offering Circular may be obtained from the undersigned.

KOENIG & STREY SECURITIES, INC.

A Registered Illinois Securities Dealer

999 Waukegan Road Glenview, Illinois 60025
Attn: Tax Shelter Dept. Phone: (312) 729-6610 or 273-2262

We are pleased to announce

a new name, a new ownership, and a new management for a psychiatric hospital

Chicago Lakeshore Hospital

formerly Fairview Hospital

Roy Kaye, Administrator
J. Herbert Maltz, M. D., Medical Director

Individualized, Comprehensive Care
providing all professionally approved treatment modalities for the neuroses, psychoses and psychosomatic disorders.

For Adults
intensive diagnostic evaluation and treatment.

For Adolescents
specialized in-depth programs including accredited schooling.

For Alcoholics
distinctive facilities with therapy administered by specialized hospital staff.

Chicago Lakeshore Hospital

4840 North Marine Drive, Chicago, Illinois 60640
(312) 878-9700

Recommendations On Smallpox Immunization

In September, 1971, the United States Public Health Service removed compulsory smallpox immunization for travelers abroad. It was recommended that the state statutes for mandatory smallpox immunization be repealed

Since that time there has been much discussion. Thus, a position statement on smallpox immunization was drafted by the Illinois State Medical Society's Council on Environmental and Community Health, which was endorsed by the ISMS Board of Trustees on October 15, 1972.

In essence, the Council on Environmental and Community Health and several authorities are urging doctors to continue immunizing against smallpox, unless specific contrary indications are present. It is preferred that smallpox immunization be administered during early childhood years.

The following are the ISMS position statement and the background information on smallpox immunization in complete form:

Position Statement
Illinois State Medical Society
Smallpox Immunization

The United States has not had a documented case of smallpox since 1949, mainly because a very high percentage of its population has been immunized and protected by cooperative programs of vaccination carried on by public health agencies, private physicians, and community, family and school organizations.

Continued freedom from smallpox epidemics can be achieved by having a continuously high percentage of the population protected against this virulent, highly contagious disease.

A very small percentage of the population may have contraindications to smallpox vaccination (2% to 5%). It also must be pointed out that primary immunization against this disease in early life shows a very low reaction. A 95% immunized population certainly would be a well-protected population and a remarkable protective goal to achieve.

Physicians and public health agencies should intensify efforts to assure that all adverse vaocine reactions are reported and that the following contraindications to smallpox vaccination are scrupulously observed:

(1) eczema and other forms of chronic dermatitis in the person to be vaccinated or in a household contact;

(2) pregnancy;

(3) altered immune states from disease or therapy.

Modern biological virologists are encouraged to seek new methods of immunization against smallpox producing less reaction and greater length of immunization.

Because of the declining incidence of smallpox in the world, and the reduced risk of its being imported into the United States, *compulsory* measures as they relate to routine smallpox vaccination could be discontinued. The School Code might be modified to remove *compulsory immunization against smallpox.*

A splendid record of low incidence of smallpox in the United States has not been achieved by non-immunization against this disease. When strictly observing contraindications as detailed above, the physician will identify those who should not be immunized. In light of this, physicians are urged to continue immunization against smallpox and to advise patients that they continue to be immunized, whether or not immunization is required by the USPHS or other countries. It is further suggested that the Illinois Department of Public Health develop public policy for Illinois whereby immunity to smallpox for preschool and school children be recommended.

The Illinois Department of Public Health, through its Department of Disease Control, should carry on an educational campaign to see that all medical and hospital personnel serving especially the areas around international airports be vaccinated periodically to show a high degree of protection, especially against smallpox. It is important that all medical and hospital personnel be immunized against this disease.

Background Paper on Smallpox

On September 25, 1971, the United States Public Health Service issued the following recommendation on smallpox vaccination in the United States.

"Because of the rapidly declining incidence of smallpox in the world and the vastly reduced risk of its being imported into the United States, health officials in the United States should consider the discontinuation of compulsory measures as they relate to routine smallpox vaccination."[1]

One year after this statement, what is the incidence of smallpox in the world and what is the feeling among public health workers who have seen smallpox epidemics?

There has not been an indigenous documented case of this disease since 1934 in this country. The reason is two-fold—the excellent work of the United States Public Health Service at points of immigration and the fact that the majority of those living in the U.S. have been inoculated against the disease sometime during their lives.

We believe that the continuance of primary vaccination in children who have no contraindications to vaccination is still an excellent public health procedure (which should be carried out between the ages of 1 and 5 when reactions are at their lowest) for the following reasons:

1. In 1970 there were 10,039,426 passenger arrivals at United States ports of entry.[2] Of these, 6,208,226 were

U.S. citizens and 3,831,200 were aliens. Interestingly enough, of the 9,353,738 departures from the U.S., 6,107,257 were U.S. citizens and 3,246,481 were aliens.

Travel to the United States has increased 291% in the last ten years and there is every indication that the trend will continue.

Transmission of smallpox into the United States is still possible by any of its visitors who are not protected and who come from epidemic areas. Epidemics are still possible.

According to the World Health Organization epidemiological report of September 2, 1972, a total of 47,872 cases of smallpox had already been reported throughout the world during 1972, an increase of 38% over the 34,697 cases recorded in this same period last year.[3]

2. During this past year 174 cases of smallpox were reported in Yugoslavia, claiming 35 deaths. The 20% mortality observed in this outbreak certifies the severity of the disease. The figures do not reflect the general body disfigurement as a result of the pocks that appeared during disease. The disease could have been prevented in an immunized individual. All of the deaths could also have been prevented if the immunization status of that nation had been kept at a protective level. The index case was believed to be a Yugoslavian pilgrim who traveled to Mecca and returned home by way of Bagdad where smallpox was known to exist at that time.

P. F. Wehrld, J. Posch, K. H. Richter and D. A. Henderson, in an extensive study of smallpox on the European continent, reported that since 1960 smallpox has been introduced into 10 European countries on 28 separate occasions.[4]

Situations similar to those occuring in Europe could be observed if America was not protected. But as long as it is protected with a high primary immunization status, there would be less panic during any vaccination emergency.

Yugoslavia did not carry out an intensive primary vaccination program in the local epidemic area prior to the last epidemic. It would be interesting to know how many people died from smallpox vaccination in the recent Yugoslavian outbreak from having their primary vaccination late in life, since it is known that complications from vaccination are more severe in later life than in early life.

3. The compulsory state laws necessary to wipe out smallpox in early days have now been repealed with the medical observation that 2% to 5% of the children born in the United States should never be vaccinated against smallpox except in an emergency and with special care. Contraindications to smallpox vaccination should be scrupulously observed to prevent excessively severe reactions, and even fatalities.

Anyone having any of the following should not be vaccinated unless absolutely necessary:[5]

A) eczema and other forms of chronic dermatitis in the person to be vaccinated or in a household contact;
B) pregnancy; and
C) altered immune states from disease or therapy.

Speedy immunization of entire population groups, regardless of the condition of the health of the population, has usually produced more reactions and deaths than were necessary. If primary smallpox vaccinations were given in early life, subsequent revaccinations would be milder and have fewer complications. Primary vaccinations given in the early years are always safer than ones given during mass immunizations.

If all children between 1 and 5 years who have contraindications to smallpox vaccination were eliminated from vaccination programs, the risk of complications would be reduced to practically nothing.

Can you imagine an army of 18-year-olds reporting for military service without previous smallpox vaccinations? One might give a month off after three or four days of vaccinations to allow time to recover from complications from adult vaccinations.

4. The United States has witnessed a mild virus with a long incubation time of smallpox infection. The usual incubation time in the U.S. strains has been 12 to 16 days thus allowing exposed persons to be protected by immediate vaccination. Virulent strains of smallpox with a short incubation time of 4 to 6 days have appeared in other parts of the world with as high as 50% mortality.

We urge that continued research be conducted in newer methods of vaccination against this old enemy. The study of modern virology may bring easier, safer methods with less danger of neurological complications after vaccination. We urge that research workers take up the challenge to produce a better smallpox vaccine.

Americans are accustomed to preventive measures in public health. A long period of education has been necessary to bring us to the point where epidemics and the security of all those whose lives are dedicated to the service of us all (our armed services, health workers, airport employees, immigration personnel). Routine primary vaccinations which offer protection should not be discontinued but improved by continued research.

Edward A. Piszczek, M.D., MPH
Ernest L. Stebbins, M.D., MPH
John Adriani, M.D.
George F. Lull, M.D.
O. K. Niess, M.D.

Footnotes

1. Center for Disease Control, "Morbidity and Mortality," *U.S. Department of Health, Education and Welfare, Public Health Service.* Vol. 20, No. 38, pp 339-345, Sept. 25, 1971.
2. Statistical Abstract of the United States 1971. *92nd Annual Edition, U.S. Department of Commerce, Bureau of the Census.* Table No. 139, p. 94.
3. Center for Disease Control, "Morbidity and Mortality," *U.S. Department of Health, Education and Welfare, Public Health Service.* Vol. 21, No. 35, September 2, 1972.
4. "Bulletin of World Health Organization, 1970," Vol. 43, p. 669-679.
5. *op. cit.*, No. 1.

Winter Driving Tips

- Put snow tires or studded tires on your rear wheels. For optimum cornering, put studded tires on all four wheels. Have a set of reinforced tire chains in your trunk.
- Have your brakes balanced to avoid skids caused by one wheel holding more than another.
- Get rid of wiper blades that streak. Fill your automatic windshield washer half full of antifreeze to avoid the formation of frost when cleaning your windshield during high-speed driving.
- Poor visibility is a winter driving hazard that's easy to overlook. After starting your motor, let it warm up while you circle your car to clean all the windows.

Second Annual

"Doctor's Job Fair"

Sunday, December 3, 1972

Regency Hyatt House

O'Hare Airport, Chicago

Hailed last year as the most effective physician placement program in the nation, the Job Fair will provide an opportunity for physicians to meet with representatives of nearly 100 communities searching for doctors. Physicians interested in establishing a new practice or relocating are urged to attend.

Detailed information on the Job Fair will be sent to physicians in the mail.

For further information contact:

Mrs. E. Duffy
360 N. Michigan Ave.
Chicago, Ill. 60601

Venereal Disease Today—Part I
Gonorrhea

By L. V. Tava, M.D., Chicago Board of Health

As a service to the physicians in Illinois, the Chicago Board of Health will present a two-part series on venereal disease. The first article is devoted to gonorrhea, and the second article, syphillis, will appear in the December issue.

Venereal disease is a major public health problem in the United States as well as in most countries of the world.

Sexually transmitted diseases are conditions usually acquired as a result of sexual intercourse or transmitted during coitus.

CASES OF VENEREAL DISEASE REPORTED IN THE UNITED STATES IN 1971

(Military Cases excluded)

Syphilis	**94,383**
Gonorrhea	**624,371**
Chancroid	**1,507**
Lymphogranuloma Venereum	**615**
Granuloma Inguinale	**103**
Total:	**720,979**

GONORRHEA

The gonococcus has a very distinct predilection for surfaces lined with columnar or transitional epithelium. It is understandable why the gonococcus cannot establish a beach-head in stratified squamous epithelium. The flat cells of the Stratum corneum are tough, keratin-containing cells, not only in layers, but interdigitated to form a physical barrier. In addition, there is only 10-15% water content in these cells, compared with 70% or more in columnar cells. The gonococcus needs moisture to survive.

The incubation period for gonococcal urethritis in the male is 2-5 days, occasionally up to 8 days or more. Penetration of the surface columnar cell layers occurs through the intercellular spaces, and the organisms reach the subepithelial connective tissue where they produce a tissue reaction with capillary dilatation and an outpouring of an infiltrate which is largely polymorphonuclear leukocytes. The inflammatory response is almost entirely due to liberation of gonococcal endotoxin.

Clinically there is a transient urethral mucoid discharge which rapidly changes to a purulent, thick, creamy discharge, composed of polymorphonuclear leukocytes, desquamated epithelium, and serum. The urethral orifice and fossa navicularis may appear red and puffey, and there may be a superficial balanitis, and sufficient edema of the foreskin to produce phimosis. These changes are also the result of the potent endotoxin-containing discharge, but the organisms rarely invade the stratified squamous epithelium which covers these areas.

Untreated gonorrhea may extend to the posterior urethra, Cowper's glands, prostatic glands, and the seminal vesicles. Gonorrhea tends to skip or lightly infect certain areas. For example, it will attack the transitional cells of the trigone of the bladder where the epithelium is firmly bound down, but uncommonly involves the rest of the bladder wall or the ureters. The vas deferens may be only mildly involved, while the epididymis is acutely infected, producing severe pain, abscess formation, scarring, and sometimes sterility on the affected side.

The anal canal is about 1½ inches long and is lined with stratified squamous epithelium, but the anorectal crypts and rectum are lined with vulnerable columnar epithelium. Gonococcal proctitis may produce no symptoms, or only a mild itching or sticky crusting at the anus. Some patients note a sense of rectal fulness, backache, and pain on defecation. The rectal mucosa may appear only slightly congested, or there may be acute inflammation with pockets of creamy pus. Diagnosis must be made by culture.

Oro-genital contact may result in gonococcal pharyngitis. The stratified squamous epithelium of the oral mucosa differs from skin in that it develops no stratum corneum, lacks sweat glands, and is continuously moist from mucous, serous, and salivary gland secretions. Columnar epithelium lines the mucous and serous glands, and is also found in the nasopharynx and around the openings of the Eustachian tubes. Several British venereologists believe that primary in-

SEXUALLY TRANSMITTED DISEASES

	ORGANISM	DISEASE
Spirochetes	Treponema Pallida	Syphilis
Bacteria	N. Gonorrhoeae	Gonorrhea
	H. Ducreyi	Chancroid
	Donovania granulomatis	Granuloma Inguinale
	Chlamydiae (P-L-T agent, Bedsoniae)	Lymphogranuloma Venereum
Virus	Viruses	Herpes simplex
		Herpes Genitalis
		Molluscum contagiosum
		Condyloma acuminata
Protozoa	Trichomonas vaginalis	Trichomoniasis
Fungi	Candida albicans	Moniliasis
Parasites	Acarus scabei	Scabies
	Phthirus pubis	Pediculosis pubis
Misc.	Mycoplasma, Chlamydiae, PPLO, Mimeae, Herellea, Gram-positive organisms etc.	Non-specific urethritis
	Chlamydiae? Viral?	Reiter's Syndrome

fection with the gonococcus probably occurs in these areas only, with the rest of the oropharynx involved subsequently.

The throat may appear almost normal, or it may be diffusely inflamed with the patient complaining of a sore throat. In severe cases tiny pockets of creamy pus may be visible, especially in the area of the tonsillar pillars and palate. The parotid duct is lined with columnar cells, and gonococcal parotitis has been reported. Diagnosis must be made by culture and sugar fermentation tests.

About 80% of women with gonorrhea are asymptomatic. The primary site of infection in the female is the columnar epithelium of the endocervix and endocervical glands. The patient may be asymptomatic, with diagnosis based on bacteriologic evidence or history of contact with an infected male. In some cases speculum examination may reveal purulent discharge from the cervical os. Occasionally milking of the urethra may yield a drop of pus at the urethral orifice or from the openings of Skene's ducts. When involved, the ducts of Bartholin's glands may be reddened, and the glands themselves are enlarged and tender. If the infection has extended to the fallopian tubes, any manipulation of the cervix is usually painful, and bimanual pelvic examination elicitis evidence of adnexal thickening and pain.

The tarsal conjunctival epithelium of both the upper and lower eyelids is columnar epithelium and susceptible to gonococcal infection, which results in an extremely purulent and destructive conjunctivitis. The gonococcus is very sensitive to silver nitrate even in a 1:4000 dilution. The Crede method in the newborn utilizes a 1% aqueous solution of silver nitrate as eyedrops. Although transient irritation of the eyes from the silver nitrate may occur, the procedure has been effective in preventing Ophthalmia neonatorum. The use of antibiotic-containing eyedrops for this purpose is still under study.

Gonococcal septicemia may result in arthritis, meningitis, endocarditis, peri-hepatitis (Fitz-Hugh and Curtis syndrome), liver abscess, and glomerulonephritis. Bacterial emboli to the skin may produce a few scattered vesicopustules with erythematous or hemorrhagic haloes.

A diagnosis of gonococcal urethritis in the male can be made by demonstrating the gonococci in the cytoplasm of polymorphonuclear leukocytes in a smear of exudate stained with Gram stain. Other Neisseriae, such as the Meningococcic and Catarrhalis groups, the Mimeae and Herellea organisms, Hemophilus vaginalis, E. coli, etc. may cause errors in smears taken from other sites. Cultures are therefore necessary for diagnosis of gonococcal infection involving cervix, rectum, pharynx, or eye.

The Thayer-Martin media is modified chocolate agar, containing Nystatin to prevent growth of yeasts, Colistin to prevent growth of Gram negative organisms, and Vancomycin to prevent growth of Gram positive organisms. The media eliminates the Mimeae and Herellea groups, E. coli and other bacteria, while permitting growth of gonococci and meningococci. Transgrow media is a further modification of the Thayer-Martin formula.

All Neisseriae produce indophenol oxidase which turns purplish-black when the dye 1% tetra-methyl-paraphenylene-diamine is added. Sugar fermentation tests differentiate gonococci from meningococci. The gonococcus oxidizes glucose to produce acid without gas formation, but does not oxidize maltose. The meningococcus oxdizes both glucose and maltose to produce acid without gas formation.

(Continued on page 535)

New Pharmaceutical Specialties

(Continued from page 510)

Indications: Temporary relief from coughing and nasal congestion associated with the common cold and sinusitis.
Precautions: Use with caution in hypertension, heart disease, thyroid disease, or diabetes; avoid MAO inhibitors.
Dosage: Children 2 to 4—one-half teaspoonful four times a day.
Children 4 to 12—two teaspoonfuls four times a day.
Supplied: Liquid—4 fluid oz. bottles

PRESAMINE Psychostimulant ℞
Manufacturer: USV Pharmaceuticals
Nonproprietary Name: Imipramine HCl
Indications: Symptoms of depression, endogenous depression more likely to respond.
Contraindications: Concomitant use MAOI drugs; hyperpyretic crisis or severe convulsive seizures, during recovery from myocardial infarction.
Warnings and Precautions: Follow package insert.
Dosage: Initially, up to 100 mg./day intramuscularly in divided doses.
Supplied: Ampuls, 2 cc - 25 mg. ◀

View Box

(Continued from page 509)

Diagnosis: *Emphysematous pancreatitis* — This is usually due to past biliary tract disease with or without accompanying pancreatitis, or it may follow surgery on the biliary tree or pancreas.

It is usually caused by a gas forming organism of Clostridria or enteric pathogenic groups and it may be hematogenous in origin or may enter the biliary or pancreatic duct from the duodenum.

When the pancreas is infected the gas formed by the organisms is in small bubbles, and it is located in the region of the head of the pancreas on the AP and behind the stomach on a lateral examination. Our case demonstrates a diffuse involvement of a markedly enlarged pancreas with multiple radiolucencies seen extending from the right side to the left side of the abdomen as outlined by the arrows on the film. Though necrosis of the pancreas and adipose tissue of the peritoneal and extra peritoneal space is one of the pathologic features of acute pancreatitis, the radiologic demonstration of these changes are only rarely seen. The radiolucencies may be due to fat saponification or to actual infection by gas producing organisms. ◀

PATENTED ACTION

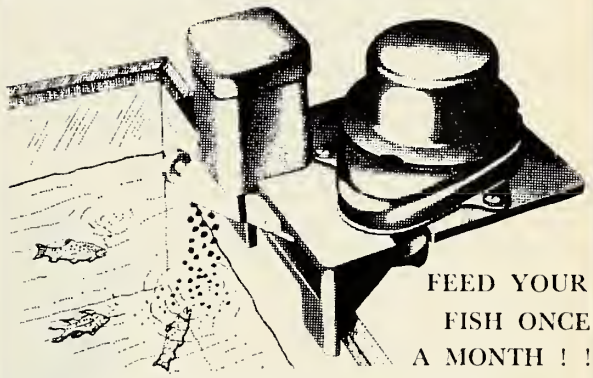
"SNAP" automatic

FISHFEEDER

for

FLAKE OR GRANULAR FOOD

$15.95



FEED YOUR FISH ONCE A MONTH ! !

The new "SNAP" fish feeder is designed to automate the daily feeding operation for your aquarium pets. Made of durable CYCOLAC plastic it is virtually indestructible under normal conditions. Simple to install and adjust--yet will run month after month unattended. Uses minimum space. Food will not cake or stick. Amount of food dispensed is adjustable to suit your needs. Holds a minimum full-charge supply of food for 30 days single feeding, refilled easily. Can be set to feed once or twice a day. Dispenses all types of commercial fish food--flake or granular. Distinct "SNAP" action summons the fish at feeding time. "SNAP" is operated by a UL approved timing motor (one year guarantee) using 110 Volt A.C. 60 Cycle house current. Units for 220 Volt, 50 Cycles available. All mechanical parts are guaranteed for 5 years.

INTERNATIONAL MERCHANDISE MART, INC.
P. O. BOX 1621
SHREVEPORT, LOUISIANA 71164

Please send me the "SNAP" automatic fish feeder. If not fully satisfied I will return it within 10 days for a full refund.

☐ **I enclose $15.95.**

Name

Address

City, State, Zip

Obituaries

**Rees, Florence M., died September 8, at the age of 77. She was a former staff physician at Mercy Hospital. Dr. Rees was a physician for more than 50 years.

*Citron, Robert, Kankakee, died August 16, at the age of 61. Dr. Citron had devoted his spare time to cancer research. He has served in state hospitals in Galesburg, Stockton, California and for the past 10 years at Kankakee.

*Artz, George E., Elmwood Park, died at the age of 81. He was a former member of the Chicago Board of Health. He held this position for 29 years. Dr. Artz also served as a surgeon for the Chicago Police Department and maintained a private practice in Cicero.

**Bendixen, Bernard O., Streator, died at the age of 80. He had been a physician for more than 50 years. During this 50 years he specialized in the field of eye, ear, nose and throat.

*Gaunt, F. Peyton, Webster Groves, died September 6, at the age of 50. He was a general practitioner and surgeon.

*Cohn, Arnold M., Chicago, died at the age of 58, on September 26. He was past president of the Bethany Methodist Hospital and was on the staff of Sweedish Covenant Hospital.

*Barnett, Harry E., Chicago, died at the age of 57 on September 30. He was an orthopedic surgeon for 30 years. He was also a member of the Michael Reese Hospital medical staff and a former chief orthopedic surgeon and consultant at Children's Memorial Hospital.

*Rasche, Herbert P., Westchester, died at the age of 63 on October 3. He was a past president of the Oak Park Hospital Medical staff.

**Newcomb, Warner H., Jacksonville, died August 17, at the age of 78. He was a physician for more than 50 years.

**Gustafson, Olga F., Chicago, died October 2. She was a physician for more than 50 years.

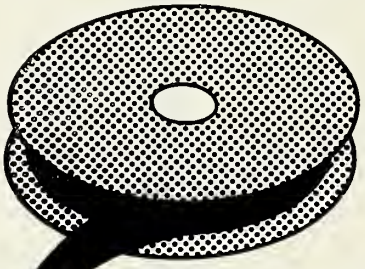
*Mansfield, Clarence E., Chicago, died September 27.

*Baur, Adolph G., Chicago, died at the age of 55 on August 2.

*Mennella, James V., Wonder Lake, died August 31, at the age of 65.

**Indicates member of ISMS.*

***Indicates member of ISMS and Fifty-year Club.*



Greatest Advance Since the Typewriter was Invented! No More Smeary Erasing—Covers Mistakes Instantly, Permanently!

SELF-CORRECTING TYPEWRITER RIBBON!

Most exciting, needed advance since the typewriter was invented! As of this moment, every messy, smudgy, smeary typewriter eraser in the world hits the scrap heap for good. No more erasing—ever! Bottom half of miracle ribbon is like a magic wand that makes errors disappear before your eyes. To make corrections, just back space, shift ribbon selector and retype error. Presto! White ink makes error completely invisible. Order extra ribbons for friends. This is one gift they'll love you for! No CODs.

MAIL ORDER MART, Dept. 14
2701 Sterlington Road, Suite 132
Monroe, Louisiana 71201

Please send me the quantity of ribbons checked below. If not satisfied, I will return ribbons within 10 days for full refund.

☐ 1 ribbon $3.50 ☐ 2 ribbons $6.00

Brand Name of Typewriter—
☐ Standard ☐ Electric ☐ Portable

Name_____

Address_____

City_____ State_____ Zip_____

Proposed Outline for Student Notes On Hospital Charts

The Council on Education and Manpower of the Illinois State Medical Society has developed guidelines for student notations on hospital charts. This outline is a result of ten months of surveying. The ISMS Board of Trustees has endorsed these guidelines.

This will be distributed to all medical schools and teaching hospitals with the suggestion that they be used or modified based upon local procedures. The purpose of the guidelines is to put forth a common method for teaching hospitals to eliminate possible malpractice situations, and to provide a basis on which meaningful educational experience may be founded while maintaining necessary safeguards.

The guidelines are as follows:

1. Medical students are required to help in patient care only when they are assigned this responsibility by a physician member of the medical school faculty or hospital. Students are not to volunteer their services in patient care except in cases of extreme emergency and then *only* under the direction of a fully licensed physician.
2. Orders and other notations written by a medical student in the patient's chart on the doctor's order sheet must be countersigned by a physician; prior to implementation.
3. When a nurse enters the fact that a medical student visited or otherwise interacted with a patient, the entry must include the student's first initial, last name, and school year designation.
4. When a student makes an entry in a patient's record he or she must sign the entry by first initial, last name and school year designation.
5. The medical student's history, physical examination and progress notes may be used as official history, physical examination and progress notes, if they are reviewed and countersigned by the attending physician before the chart reaches the medical records room. If the history, physical examination and progress notes are not countersigned, they are to be removed from the chart in the medical record room or department, and discarded or returned to the student.

★

Specialized Service

IN

PROFESSIONAL LIABILITY INSURANCE

is a high mark of distinction

THE

MEDICAL PROTECTIVE COMPANY

FORT WAYNE, INDIANA

Professional Protection Exclusively since 1899

CHICAGO AREA OFFICE: T. J. Pandak, J. C. Kunches, and L. R. Gonnon, Representatives
T. J. Hoehn, Consultant
815 Commerce Drive, Suite 102, Oak Brook, Illinois 60521 (312) 325-7314
SPRINGFIELD OFFICE: W. J. Nottermonn, Representative
426½ South Fifth Street, Springfield 62701 (217) 544-2251

CLASSIFIED ADVERTISING

Positions & Practice Opportunities

OB-GYN, GP, INTERNIST, QUINCY, ILLINOIS—2 modern hospitals with newest equipment, our office within two blocks. Above average earnings. Earnings guaranteed. Ranges to six figures. Positions available now. Educationally and culturally rated with best in state. Many recreational facilities. For details call collect 217-223-0505. Irving Brenner, Administrator.

PHYSICIAN WANTED—For general practice, or general practice and orthopedic surgery. Attractive, prosperous, residential community of Geneseo with over 6,000, serving trade area of 29,000 population. Located on Interstate 80, 2½ hours from Chicago and 25 miles east of Quad-Cities metropolitan area of over 300,000 provides safe, ideal, small city living for family with excellent recreational facilities. New ultra modern $2,500,000 hospital with 110-beds. Office space and housing immediately available. Contact: Clement G. McNamara, 210 Elk Street, Geneseo, Illinois or phone collect: (309) 944-6431.

WANTED GENERAL PRACTITIONER, specializing in industrial medicine. Permanent position in modern northwest Clinic. Forty hour week, good salary, fringe benefits. Illinois Licensure a necessity. 'Phone Miss Schofield—(312) BE 7-8000.

PHYSICIAN FOR ACUTE ILLNESS DEPARTMENT and Emergency Room. Become a part of an expanding, dynamic multispecialty clinic in Midwest university community. Excellent salary, benefits. Write or call Medical Director, Carle Clinic, Urbana, Illinois 61801. Phone (217) 337-3239.

UNIVERSITY HEALTH SERVICE POSITIONS OPEN: General Practitioner, Pediatrician, or Internist, full-time, for Medical Clinic. General Practitioner, full-time or Gynecologist for office gynecology and family planning services. (Gynecologist may elect to practice part-time in Chicago or Rockford.) Psychiatrist, full-time, for patient therapy and to head Mental Health Unit. Modern facility, good fringe benefits. Illinois license required; salary per qualifications. L. W. Akers, M.D., Director, UHS, Northern Illinois University, DeKalb, Illinois 60115.

IMMEDIATE OPENING far OB-GYN, Internal Medicine, and Orthopedic specialties to establish successful practice with 14-man multi-specialty group. Excellent group benefits; pension plan; modern clinic facilities; progressive cammunity with excellent educational system including two colleges; city populatian 35,000; good recreational facilities; each specialty must be board eligible or certified; young man with military obligatian completed. Contact: Business Manager, The Manitowoc Clinic, 601 Reed Avenue, Manitowoc, Wisconsin 54220.

WANTED: OB-GYN, SURGEON and INTERNIST for nine man group. Thirty miles southwest of Chicago, excellent hospital, housing and schools. $30,000 guarantee first year. Write to Box Number 782, c/o Illinois Medical Journal, 360 N. Michigan Ave., Chicago, Illinois 60601.

IMMEDIATE OPENING: INTERNIST or GENERAL PRACTITIONER to join six man multi-specialty group in northeastern Wisconsin. Excellent professional opportunity to practice in a friendly community, only two actively practiticing physicians (General Practitioners) in the community outside of our Clinic. Salary commensurate with training and experience first year and then full partnership. Ideal, safe small city living for the family on scenic Lake Michigan with excellent fishing, boating and hunting. All this and still only 1½ hours drive to Milwaukee or 45 minutes to Green Bay or lovely Door County. For complete details contact Robert E. Myers, M.D., Garfield at 23rd. Two Rivers, Wisconsin 54241.

GENERAL PRACTITIONER—Excellent location in the Lost Pines of Texas area, growing community of 3,500 along the beautiful Colorado River. Has an excellent opportunity for a good family General Practitioner. Excellent small Haspital (25 beds) and Nursing Home (65 beds) complex, guaranteed salary if desired, clinic, ancillary services and other fringe benefits will make this difficult to turn down if interested in working in a progressive rural community only 40 miles from a metropolitan area. Smithville Hospital Authority; Irvin Row, Administrator, Box B9, Smithville, Texas 78957. Phone: AC 512-237-2441.

OPENING FOR PHYSICIAN (GENERAL MEDICINE OR INTERNIST) on Medical Service, 184-Bed GM&S VA HOSPITAL well equipped and staffed including consultants. Affiliation with SIU School of Medicine. Beginning salary depending on qualifications. Excellent vacation, insurance and retirement benefits. No maximum age. Excellent area recreational facilities and cultural activities at nearby Southern Illinois University. Equal Opportunity Employer. Inquire: Director, Veterans Administration Hospital, Marion, Illinois 62959. Call (618) 993-2151.

PATHOLOGIST WANTED: Board eligible, Illinois licensed for vacation coverage. $600 per week. Contact James Gross, M.D., pathologist, St. Mary's Hospital, Streator, Illinois 61364. Phone: (815) 673-2311 Ext. 219.

EMERGENCY CENTER PHYSICIANS—full-time, for Lake County Memorial Hospitals, Willoughby and Painesville, Ohio. $25,000 basic salary, plus opportunity for additional income. Liberal fringe benefits, including professional liability insurance. Must have Ohio license. Contact: W. E. Fletcher, M.D., 89 E. High Street, Painesville, Ohio 44077.

PART-TIME LOCUM in Beautiful Suburban Clinic. Hours arranged to suit. General and E.R. Practice. Liberal Hourly Salary. Write: G. A. Caress, 2320 W. High Street, Blue Island, Illinois 60406, or Call (312) 388-5500.

GENERAL PRACTITIONERS WANTED—Are you bored and want a challenge? Do you want to practice where they don't ask about your diploma, or your specialty? Are you genuinely interested in people and their problems, rather than diseases and cases? If so, come on down to Fairfield and get your feet wet! Write or phone collect: Jerry Vaughan, Box H, Fairfield, Illinois 62837. Telephone (618) 842-2167.

PSYCHIATRIC STAFF—Requirements of three year residency training to Board Certified. $26,000 to $36,000 depending upon qualifications. Dramatically beautiful, leisurely paced cultural, summer-winter vacationland. Superb sailing, skiing, fishing. Resident theater. Near Interlochen National Music Camp. College. J.C.A.H. approved 1,400 bed psychiatric hospital. Three year psychiatric residency program. Excellent fringe benefits. Contact Philip B. Smith, M.D., Room 321, Traverse City State Hospital, Traverse City, Michigan 49684. An equal oportunity employer.

WANTED . . . PHYSICIAN to practice in new clinic. Ideal location in county seat of Marquette County. Progressive community in resort and recreation area. Excellent place to live. Contact: Mayor Ken Bentley, Montello, Wisconsin. Telephone: 297-2474.

G.P.'s, INTERNISTS, ORTHOPOD, GENERAL SURGEON, PEDIATRICIAN—Growing H M O adding to staff for two new medical centers to be opened in 1973. Competitive salary, bonus & tax sheltered fringe benefits such as retirement, sobbaticals, etc. Send curriculum vitae to Henry C. Cosand, M.D., Family Health Program, Room 11211, 2925 North Palo Verde Avenue, Long Beach, California 90815.

ANESTHESIOLOGIST ASSOCIATE NEEDED. Responsibility includes over-seeing a five male anesthetist Anesthesia Division and an active Pulmonary Care Division. Private 265-bed hospital includes open heart surgery, pediatrics intensive care, CCU and ICU. Salary and fringe benefits are excellent. Illinois University town setting. Locum tenens also available. Write to Box Number 805, c/o Illinois Medical Journal, 360 N. Michigan Ave., Chicaga, Illinois 60601.

FOR SALE, LEASE OR RENT

NOW LEASING! New, modern, air conditioned Medical Center in Buffalo Grove, Illinois adjacent to Arlington Heights. Ample parking. Join other specialists in this established medical center in a rapidly growing Northwest Suburban area. 480 square feet available for: Ophthalmologist, Optometrist, Orthopedic Surgeon, Urologist, General Surgeon, Psychiatrist, Neurosurgeon, Psychologist, Physical Therapist. Call: Earl Sauter, Agent A/C 312 537-8880.

MEDICAL BUILDING, MOLINE, ILLINOIS—Outstanding opportunity for professional man starting his practice or planning relocation of his practice. Beautiful modern office with all modern facilities only half mile from modern hospitals area Trauma Center in Illinois. Call (309) 762-3397. Moline, Illinois.

OFFICE SPACE in excellent location available for General Practitioner or Specialist. Call (312) 746-2046—Zion, Illinois.

FOR RENT AND SALE: Office Space, ideal location, west suburban Bellwood: furniture and medical equipment for sale due to death of physician. Certain items such as spectrophotometer (new), EKG, laboratory items, Coleman diathermy, new electronic stethoscope for sale, separately if desired. Practice also may be assumed through orrangements with Executor. Write Box Number 806, c/o Illinois Medical Journal, 360 North Michigan Ave., Chicago, Illinois 60601.

PRACTICE FOR SALE—Estate Sale, Marshall Erdmann Medical Building, 1500 sq feet, 9 rooms, 3 examining rooms, Central air conditioning and heating, modern facilities and equipment including X-ray. Situated in quiet, scenic Southern Illinois—mild climate. (2) hospitals within 5 mile radius, on major transcantinental travel routes; Major University with Law and Medical School 20 miles away. Fantastic recreational possibilities nearby; 230,000 acres Shawnee National Forest—superb hunting and fishing in 20 minutes drive: 9 major lakes and 2 major rivers. Foreign born medical graduate grossed far into six figures here. Ideal for one or two doctors. Please call collect (618) 983-7301 or send inquiries to Mrs. Rotraud Rupprecht, 802 Washington, Johnston City, Illinois 62951.

FOR SALE: Lucrative 25 year old general practice one hour drive from Downtown Chicago. Will introduce. Unlimited opportunity for mole ond female medical doctors. Write to Box Number 807, c/o Illinois Medical Journal, 360 No. Michigan Ave., Chicago, Illinois 60601.

OFFICE PRACTICE in CHICAGO for sole. Retiring. Lucrative Bariatric Practice (WEIGHT CONTROL). Write to Box Number 809, c/o Illinois Medical Journal, 360 N. Michigan Ave., Chicago, Illinois 60601.

EXCELLENT CHICAGO GENERAL PRACTICE. Doctor moving for heolth reasons must sacrifice proctice locoted in prime medicol building. Grossing $85,000. Total purchose price $5,000. Buyer also hos opportunity to purchase 25% interest in medicol building.

SMALL OAK PARK FAMILY PRACTICE. Physicion retiring.

OTHER EXCELLENT PRACTICES AVAILABLE throughout Illinois, Wisconsin and Indiona. No fee to buyers. Financing available. Strictly confidentiol.

PROFESSIONAL PRACTICE SALES, 540 Frontage Road, Northfield, Illinois 60093; 312/441-6111.

Positions Wanted—Paramedical*

ILLINOIS LICENSED OPTOMETRIST—Woman experienced in refroction and dispensing available for part-time position in ophthalmologist's office or clinic in Evanston-North Shore area. For more information, write Box Number 808, c/o Illinois Medical Journal, 360 N. Michigan Ave., Chicogo, Illinois 60601.

MEDICAL ARTICLES FOR SALE

SURGICAL PATHOLOGY MODELS, over 200 specimens, carefully selected over 20 year period. Each documented. Lobeled. Ideal for medical staff teaching and resident training. Offered as a "gift" to a tax exempt, non-profit institution. Write to Box Number 804, c/o Illinois Medicol Journal, 360 N. Michigon Avenue, Chicogo, Illinois 60601.

FOR SALE—1 FLUOROSCOPE MACHINE, 8 years old. Best Offer. Coll: (312) SP7-5450.

NOTE:
*Professional qualifications of Paramedical Personnel are subject to review by prospective physician employers.

VD Today—Gonorrhea

(Continued from page 530)

In most cases resistance of a gonococcal strain to penicillin is relative, the strain showing susceptibility if a high enough penicillin level is reached. At the present time gonococcal cultures often require 0.5 units per ml. penicillin or more to inhibit growth. Experimental evidence based on treatment results indicates that penicillin blood levels of 3 to 10 times the minimal inhibitory concentration of the organism in vitro are required for cure of the actual infection.

The gonococcus divides by binary fission, taking 15-18 minutes to complete division. The Treponema Pallida divides by transverse fission, which requires 30-33 hours for completion of the process. Penicillin acts by impairment of cell wall synthesis during cell division. Since the gonococcus divides rapidly but needs a high penicillin blood level, a penicillin preparation is selected such as aqueous procaine penicillin G, giving 4,800,000 units i.m. if the patient has no known allergy to penicillin, this dosage producing a high penicillin blood level for 24-36 hours. Probenecid is given orally preceding the injection to suppress renal tubular excretion of penicillin.

The Treponema Pallida are extremely sensitive to the action of penicillin; but cell division is slow and not continuous. Therefore, in treating syphilis a penicillin preparation such as Benzathine penicillin G is selected, which gives a lower penicillin blood level but maintains a level for 20 days or more.

Suggested schedules for the treatment of gonorrhea and its complications are given in an accompanying article. Management of the disease is not complete until the case is reported to the city or state health department and epidemiological measures have been taken. ◄

IMJ
Illinois Medical Journal

your advertisers

Our Advertisers serve the Medical Profession and support your Journal. All advertisers are approved by your Journal Committee. It will help you and your society to mention your Journal when writing them.

Space Representatives:
United Media Associates, Inc.
16 Bruce Park Avenue
Greenwich, Conn. 06830

CLASSIFIED ADVERTISING 534-535

INSURANCE
- Medical Protective 533
- Parker, Aleshire, & Co. 512, 524

PHARMACEUTICALS
- Arch Laboratories
 - *Dicarbosil* 523
- Ayerst Laboratories Div., American Home Products, Inc.
 - *Premarin* 450-451
- Beecham-Massengill Div., Beecham, Inc.
 - *Antibiotics* 446
- Burroughs Wellcome & Company
 - *Neosporin Ointment* 2nd Cover
- Endo Laboratories, Inc.
 - *Percodan* 460-461
- C. B. Fleet Co., Inc.
 - *Fleet Enema* 465
- Geigy Pharmaceuticals
 - *Preludin* 453
- Eli Lilly and Company
 - *Ilosone Liquid 250* 466
 - *Trinsicon* 513-514
- Wm. Poythress Co., Inc.
 - *Uro-Phosphate* 457
- A. H. Robins Co., Inc.
 - *Dimetapp* 519
 - *Phenaphen* 520-521
- Roche Laboratories
 - *Librium* 462-463
 - *Valium* Back Cover
- Sandoz Pharmaceuticals
 - *Hydergine* 458-459
- Smith, Kline & French Labs.
 - *Orinade* 464
- Stuart Pharmaceutical Div., Division of I.C.I. America Inc.
 - *Mylanta* 443
 - *Kinesed* 454-455
- The Upjohn Company
 - *Orinase* 444
- Westwood Pharmaceuticals, Inc.
 - *Alpha Keri* 505

SERVICES & CONTINUING EDUCATION
- American National Bank 511
- Blue Cross/Blue Shield 441-442
- Chicago Lakeshore Hospital 525
- Cook County Graduate School of Medicine 523
- International Merchandise Mart, Inc./*Fishfeeder* 531
- Koenig & Strey Securities, Inc. 524
- Mail Order Mart/*Typewriter Ribbon* 537
- Pharmaceutical Manufacturers Association 447-449

BLUE SHIELD REPORT FOR Illinois Physicians

Insufficient Information Delays Payment

Delays in payment of Blue Shield claims often result from the absence of information or incorrect completion of the forms. The problem is further intensified with the increase in number of Blue Shield subscribers receiving a broader scope of benefits and the higher volume of Physician's Service Reports received by Blue Shield.

Revisions to the present Physician's Service Report forms are being made by Blue Shield and were discussed at the dinner and daytime workshops held for medical assistants during the year. New Service Report forms for anesthesiologists and radiologists were also discussed at the workshops. When the new forms are completed, they will be mailed to physicians for their use.

Many delays can be eliminated or reduced by following a checklist when completing the Physician's Service Report forms. The checklist that follows has been helpful to many doctors and their office assistants when completing and submitting the Service Reports for payment.

(1) Copy group and subscriber number exactly as shown on the patient's Blue Shield Identification Card. (Please do not include the codes shown on the card).

(2) Provide exact spelling of patient's and subscriber's name. (Please print or type name as it appears on member's card).

(3) Indicate age of the patient.

(4) Designate place of services (hospital inpatient, hospital outpatient, office, home).

(5) Include dates of service, including date of admisssion and discharge from the hospital; date of surgery, if any; and number of daily hospital visits, if for medical (non-surgical) care.

(6) Indicate if an injury occurred at patient's place of employment. (Give nature of injury and how it occurred.)

(7) Provide diagnosis, standard name of operation, if any, and sufficient descriptions. For example:

Vein Ligations—Stripping, multiple resections, both greater and lesser saphenous, unilateral or bilateral.

Lacerations—Location, length, depth and identify vessels, muscles and tendons repaired, if any.

A copy of the operative report attached to the Physician's Service Report may be used but is not necessary. When reporting surgical procedures, please do not use such names as "Strassman procedure" or "Nissen procedure". The use of standard medical nomenclature will prevent delays in payment.

(8) Please describe unusual circumstances.

(9) Check only the type of service personally rendered, indicating date(s) and description of service(s). If other physicians have also rendered service, each must submit his own Physician's Service Report.

(10) Indicate the fee for each service reported and whether the fee has been paid by the patient.

This is particularly important in order to make payment to physicians on the basis of their Usual charges for those Blue Shield members who are protected by our Usual and Customary program.

(11) Claims for anesthesia services should include the following information on the Blue Shield Service Report:

(a) Type of procedure
(b) The time of the anesthesia
(c) The charge for anesthesia

Particular attention should be given to claims submitted for anesthesia administered during a dilation and curettage procedure. Please indicate whether the procedure was performed for obstetrical or non-obstetrical purposes.

(12) Claims for radiation therapy are often delayed because the diagnosis is not included on the Physician's Service Report. By reviewing the claims before they are submitted to Blue Shield, unnecessary delay can be prevented and the necessity to contact you for additional information can be avoided.

(13) Signature of the physician rendering the service must be on the PSR.

(This report is a service to the physicians of Illinois)

ASK BLUE SHIELD
. . . ABOUT MEDICARE

CHANGES ANNOUNCED IN PART A AND PART B MEDICARE DEDUCTIBLES

The Secretary of Health, Education and Welfare, recently announced changes in Part A (Hospital Insurance) and Part B (Medical Insurance) deductibles, effective January 1, 1973.

The Part B deductible will be increased from $50.00 to $60.00. This is the first increase in the Part B deductible since the Medicare law was enacted in July, 1966.

Part A inpatient hospital deductible will be increased from $68.00 to $72.00 for benefit periods beginning in 1973. Under a formula included in the Medicare law, the Secretary of HEW is required to determine each calendar year the amount of inpatient deductible applicable for benefit periods beginning the following calendar year. Under this formula, the deductible for 1973 would have gone from $68.00 to $76.00, but a ruling by the Price Commission reduced the increase from $8.00 to $4.00.

The Cost of Living Council ruled that the new deductible represents a price paid by Medicare recipients for hospital services, and is, therefore, governed by the Price Commission regulating the limit on increase in prices charged by institutional providers of health services. The Price Commission, therefore, held the increase to 6 percent.

The year in which the patient's benefit period begins determines not only the deductible amount to be applied during the benefit period, but also the coinsurance amounts applicable to days of inpatient hospital services after 60 days have been furnished; to lifetime reserve days; and to the coinsurance amount for Extended Care Facilities services. Thus, the $68.00 deductible is applicable in the situation where a Medicare patient begins a benefit period with a hospital stay beginning in 1972, even though he receives services in 1973—so long as the benefit period has not terminated.

If the benefit period begins in 1973, the deductible amount will be $72.00; the coinsurance amount for a day of inpatient hospital services from the 61st day through the 90th day will be $18.00 per day; for each lifetime reserve day $36.00; and for an Extended Care Facility day, from the 21st day through the 100 day, $9.00 per day.

TIME LIMITS ESTABLISHED FOR FILING PART B MEDICARE CLAIMS

Compliance with time limits for submitting Part B Medicare claims is requested by the Social Security Administration. All claims for services rendered prior to October 1 of one year must be submitted by December 31 of the following year. However, services and supplies provided during the last three months of the calendar year are considered to have been provided in the following year. (Any charges applied to the deductible during the months of October, November and December of one year may be applied to the deductible for the following year.)

Below are some examples of the time limits:

For Services Rendered from	Claims Must Be Filed by
October 1, 1970-September 30, 1971	December 31, 1972
October 1, 1971-September 30, 1972	December 31, 1973

When a physician accepts an assignment within the allowed time limits, but then delays filing the claim beyond the time limit allowed, special provisions apply. If the claim is $300 or less, the physician may bill the patient for only 20 percent of the total amount of the claim, and not for any charges that would have been applied to the Part B deductible. When the charge is more than $300, the carrier will assume the deductible has been met, determine the reasonable charges, and advise the physician and patient that it is the patient's responsibility to pay 20 percent of the reasonable charge.

Immunizations

Vaccinations or innoculations are excluded from coverage unless they are directly related to the treatment of an injury or direct exposure to a disease or condition. In the absence of an injury or direct exposure, preventive immunizations (vaccination or innoculation) for such diseases as smallpox, polio, diptheria *are not covered.* Influenza injections are administered as a preventive measure and are excluded from coverage without regard to the patient's particular susceptibility to influenza.

SSA Change in Lab Certification

The Social Security Administration no longer considers the following laboratory to be certified for Medicare participation:

K & K CLINICAL LABORATORY
5935 West Addison Street
Chicago, Illinois 60634

(This report is a service to the physicians of Illinois)

IMJ illinois medical journal

volume 142, number 6 december, 1972

staff

editor Theodore R. Van Dellen, M.D.
managing editor Richard A. Ott
assistant editor Joyce Sevits
executive administrator Roger N. White

Abstracts of board actions 544
Cumulative index, volume 142 612

clinical articles

Prolonged pregnancy a problem of declining placental function
Laurence I. Burd, M.D. and Antonio Scommegna, M.D. 559
Diagnosis and treatment of common bleeding disorders
Joseph A. Caprini, M.D., M.S. and E. S. Kurtides, M.D., F.A.C.P. 564
Licensure and credentialing of health manpower
Morton C. Creditor, M.D. 569
The future for long term care
Bertram B. Moss, M.D. 577
Maternal death study no. 9
Robert R. Hartman, M.D. 584

special articles

Industry's response to nutritional challenges
R. E. Smith, Ph.D. 573
Venereal disease today, part II
L. V. Tavs, M.D. 588

trauma center

The injured posterior urethra
Samuel S. Clark, M.D. 588

features

presidents page 554
investment corner 581
view box 582
ekg of the month 583
clinics for crippled children 585
pulse of the doctors wife 586
what goes on 602
membership forum 603
practice management 606
obituaries 608

(cover by Annette Barbier)

Microfilm copies of current as well as some back issues of the *Illinois Medical Journal* may be purchased from Xerox University Microfilms, 300 North Zeeb Road, Ann Arbor, Mich. 48106.

Published monthly by the Illinois State Medical Society, 360 N. Michigan Ave., Chicago, Ill., 60601.
Copyright, 1972, The Illinois State Medical Society.
Subscription $5.00 per year, in advance, postage prepaid, for the United States, Cuba, Puerto Rico, Philippine Islands and Mexico. $7.50 per year for all foreign countries included in the Universal Postal Union. Canada $5.50 U.S. Single current copies available at 75c.

Second class postage paid at Chicago, Ill. and at additional mailing offices. When moving please notify Journal office of new address including old mailing label with notification, if possible. POSTMASTER: Send notice on form No. 3579 to Illinois State Medical Society, 360 N. Michigan Ave., Chicago, Ill. 60601.

Pharmaceutical advertising must be approved by the ISMS Publications Committee. Other advertising accepted after review by Publications Committee or Board of Trustees. All copy or plates must reach the Journal office by the fifteenth of the month preceding publication. Rates furnished upon request.

'Original articles will be considered for publication with the understanding that they are contributed only to the Illinois Medical Journal. The ISMS denies responsibility for opinions and statements expressed by authors or in excerpts, other than editorial or allied views or statements which reflect the authoritative action of the ISMS or of reports on official actions, policies or positions. Views expressed by authors do not necessarily represent those of the Society; any connection with official policies is coincidental.

REGISTERED ABP MEDIA DATA FORM


When irritable colon feels like this

Send her home with an APC/narcotic that doesn't contain codeine

Percodan does what you want an APC/narcotic to do: It effectively relieves moderate to moderately severe pain. But it's different from all the other widely prescribed APC/narcotics because it doesn't contain codeine.

The chief analgesic agent in Percodan is oxycodone. A semisynthetic narcotic analgesic, oxycodone represents a therapeutic alternative to codeine. Percodan can produce drug dependence of the morphine type and has the potential of being abused. Percodan should be used with the same degree of caution appropriate to other oral narcotic-containing medications.

One tablet of Percodan every six hours is usually sufficient for adults. However, it occasionally may be necessary to exceed the usual dosage in cases of severe pain or in those patients who have built up a tolerance to the analgesic effect of narcotics. Percodan. The APC/narcotic that doesn't contain codeine.



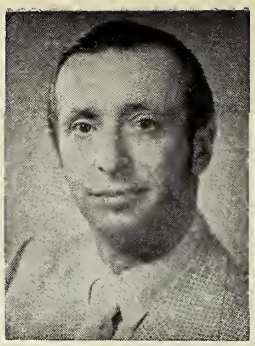
Percodan® C II

Each yellow, scored tablet contains 4.50 mg. oxycodone HCl (Warning: May be habit-forming), 0.38 mg. oxycodone terephthalate (Warning: May be habit-forming), 224 mg. aspirin, 160 mg. phenacetin, and 32 mg. caffeine.

reliable pain relief without codeine

Please refer to brief summary on facing page.

the presidents page



"The People of Illinois Deserve No Less"

(Dan Walker—September 15, 1972)

With these words, Governor-elect Dan Walker concluded his campaign position paper on health. In his paper, Walker focused on four areas ". . . where government and the medical profession MUST work together: (1) comprehensive planning of health care services; (2) the expansion of preventive medicine; (3) the state's responsibility as a purchaser of medical services; and (4) the education of health manpower."

Additionally, Walker made these specific proposals:

- Revision of policies for disbursing the multi-million dollar state medicaid payments.
- Supplemental insurance plans for victims of long term illnesses.
- Locating responsibility for nursing and shelter care homes under one agency, instead of the present split of responsibility among the Departments of Public Health, Public Aid and Mental Health.
- State leadership and assistance in creating public health programs for the 42 Illinois counties that presently have no local health department.
- Strong support to medical education in order to meet Illinois' increasing need for medical manpower.

While, in this limited space, it is not possible to comment on the specific proposals contained in the Walker position paper, it is possible to suggest an overall objective for the Illinois State Medical Society.

During the next four years, I believe the Illinois State Medical Society should do everything possible to help Governor-elect Walker and his administration establish the most comprehensive and effective health care delivery system conceivable.

Granted, we may disagree at times as to the best means of accomplishing this objective, but I am confident we will always be working for the same goal—continued improvement in Illinois' health care system.

I fully agree . . . "THE PEOPLE OF ILLINOIS DESERVE NO LESS."

Frank J. Jirka Jr. M.D.

IMJ
Illinois Medical Journal
Vol. 142, No. 6, December, 1972

Prolonged Pregnancy A Problem of Declining Placental Function

By Laurence I. Burd, M.D. and Antonio Scommegna, M.D.

Few topics in the obstetrical literature have generated as much debate as the subject of prolonged pregnancy. Opinions as to the management of this condition vary from those who recommend induction of labor in all patients whose pregnancy has gone beyond the 42nd week of gestation, to those who express no concern and allow their patients to wait for the spontaneous onset of labor.

Definition

The duration of pregnancy for humans is ten lunar months, 40 weeks or 280 days when calculations are made from the first day of the last menstrual period. If an infant is delivered within a period of two weeks prior or two weeks after the expected date of confinement, the pregnancy may be considered as a term gestation. After this period most authors would agree to consider the pregnancy as prolonged.

Incidence

The incidence of prolonged pregnancy is 8 to 10% after the 42nd week and 3 to 5% after the 43rd week.[1-5] The wide range of variation reported in the literature may be due to the method of selecting patients to be studied according to the date of their last normal menstrual period. Many patients have difficulty remembering this date. Several authors agree that prolonged pregnancy is more frequent in younger patients[1-4] and among those of low socioeconomic status,[2] while neither parity[3,4] nor race[3] seem to be a factor. No consistent relationship can be found between prolonged pregnancy and various antepartum complications such as toxemia, anemia, first or third trimester bleeding.[3] The only entities frequently associated with



Laurence I. Burd, M.D., USAF, MC, is Chief, Obstetrics and Gynecology, USAF Hospital, Grand Forks AFB, North Dakota and is lecturer at University of North Dakota.



Antonio Scommegna, M.D., is Professor of Obstetrics and Gynecology at the Pritzker School of Medicine of the University of Chicago and Chairman, Department of Obstetrics and Gynecology at Michael Reese Hospital and Medical Center.

prolonged gestation are fetal congenital anomalies, in particular, anencephaly. Malic[6] reported that in a series of 66 pregnancies complicated by anencephaly excluding those artificially terminated, 40% were post term.

Etiology

The exact etiology of this syndrome is unknown. The association of a congenital neurologic malformation such as anencephaly with prolonged pregnancy is not limited to the human. In Guernsey cattle a syndrome consisting of a fetus with a cyclopean defect and visual abnormalities is associated with post term pregnancy. A similar syndrome can be seen in sheep which seems to be related to the ingestion of a plant, *Veratrum californicum* by the pregnant ewe during the tenth to fifteenth day of gestation.[7] Although attempts to isolate the specific neurologic lesion responsible have been made, no final answer is forthcoming. In the experimental animal, destruction of the fetal pituitary gland,[8] fetal decapitation[7] and adrenalectomy[9] all appear to increase the incidence of prolonged pregnancy. These findings imply that fetal factors are important in determining the length of gestation. The feto-placental weight ratio is considered by some to be most important, and the ability of the placenta to satisfy the metabolic needs of the fetus may be the factor that determines the length of gestation.

Significance

Prolonged pregnancy must be viewed in the light of the decreasing functional efficiency of the placenta as an organ of metabolic interchange between the mother and fetus. This approach may bring some clarity into the divergent opinions concerning the significance of the post date pregnancy as the cause of perinatal mortality and decreased birth weight, occurrence of dysmaturity, fetal distress and indications for operative intervention.

The majority of investigators consider the period of prolonged gestation as hazardous for the fetus. The incidence of perinatal mortality is increased, particularly the number of stillbirths.[2,5,10,11] In those patients who present additional fetal risks such as primiparas, elderly gravidas[1,5,11,12] and patients with toxemia perinatal death is highest.[5] Mortality also increases when labor is prolonged.[5] Some investigators consider that the increase in perinatal mortality is due to placental insufficiency, stating that the metabolic margin of safety for the fetus is markedly reduced.[11,13] Others believe that the problems arise from the high incidence of large babies and the obstetrical complications which occur from the delivery of these infants.[14] Both factors most probably are important. McKeown and Record have shown that there is a decline in the growth rate of the fetus at about 38 weeks.[15] This decrease is *not* a result of a diminished potential for accelerated growth since the more rapid growth rate is resumed after birth. We must conclude that the ability of the placenta near term to satisfy the fetal metabolic needs for "normal" growth is diminished.

In cases where the placenta ages rapidly the fetus will exist beyond the term date in a progressively malnourished state. Such a prolonged pregnancy will produce a dysmature infant suffering from chronic metabolic fetal distress. Clifford[16] has divided such dysmature infants into three groups depending upon the severity of the placental dysfunction. In the first group the babies are least affected presenting only scarce or absent vernix caseosa and signs of recent loss of weight. They appear long and thin. The second group includes babies with the above signs and meconium stained skin, fetal membranes and amniotic fluid. In the third group the infants are affected even more severely. The nails, skin and umbilical cord are stained deeply yellow. The amniotic fluid is very scant in amount or completely replaced by thick meconium. The infant's skin is wrinkled and has the appearance of an old man. (Fig. 1)



Fig. 1. Dysmature baby weighing 2500 grams (Clifford group 3) delivered by Cesarean Section at 44 weeks gestation in a 21 year old Gravida I. Note wrinkled skin and "old man" appearance. Amniotic fluid replaced by thick meconium.

On the other hand, the decrease in placental function may be minimal, and a prolonged pregnancy may result in a large infant. This infant, however, also has a decreased metabolic reserve. In either case, whether large or dysmature, if the infant has not succumbed its hostile intrauterine environment, a difficult labor may be the final stress to cause its demise.

Prolonged pregnancy is therefore a problem of placental function. If the placenta is insufficient in its ability to supply metabolic needs of the fetus at term, any period past this time will be increasingly hazardous. To manage these pregnancies the physician must assess the degree of this insufficiency and conduct the pregnancy according to these findings.

Management

Evaluating placental performance has been the greatest problem. Those who advise induction of labor in all pregnancies past 42 weeks duration did so after they realized the increased hazard of perinatal mortality.[17] At the time, however, there was no method of determining exactly which infants were at risk. In the past five years several methods have become available which provide the obstetrician with some insight as to the presence or absence of placental insufficiency.

Certainly we must begin with an adequate history from the patient as to the time of the last normal menstrual period. Patients who have stopped oral contraceptives immediately before becoming pregnant may not have ovulated until 40 days after their last "pill period." Consequently their expected date of confinement may actually be one to two weeks later than that calculated by Naegele's rule. Seeing a patient early in pregnancy will help clarify this problem; it also will allow the physician to determine the duration of the pregnancy according to uterine size since this is more easily done during the first trimester. It is important to record when quickening, the feeling of fetal movement; first occurs since this takes place with regularity in the primigravida at 18-20 weeks and in the multipara at 16-18 weeks.

Various clinical signs have been mentioned as indicative of placental insufficiency at term. These include a decrease in maternal weight and in the size of the uterus. Both factors result from a decrease in amniotic fluid volume which diminishes rather rapidly after 38-40 weeks.

Clinical signs

Frequently, when the patient has not been followed closely during her pregnancy, and she presents a baby that by palpation is small for the calculated dates, the actual duration of gestation is difficult to determine. Has this patient miscalculated her dates or is this infant suffering from placental insufficiency? X-rays demonstrating calcification of the distal femoral epiphyses which occurs at the 36th week may be helpful. They also may reveal the amount of subcutaneous tissue of the fetus which increases as term approaches. Also, placental calcification may suggest areas of infarction and degeneration. The components of the amniotic fluid have been found to vary according to the length of gestation. A creatinine concentration greater than 2 mgs.% is usually associated with a fetus of 37 weeks gestational age.[18] A relationship between amniotic fluid osmolality and length of pregnancy has also been noted with the osmolality decreasing as the pregnancy progresses.[19] When the osmolality is 250 m osm/liters or less fetal maturity is suggested. Investigators in the field of erythroblastosis fetalis have found that spectrophotometric analysis of the amniotic fluid revealed a peak at 450 A° in normal infants not affected by this disease prior to the 36th week. This is due to the bilirubin content of the amniotic fluid. After 36 weeks this peak disappears[20] apparently coincidental with maturation of the enzyme system of the fetal liver. Fetal cells in the amniotic fluid can be stained with Nile Blue and the ratio of orange staining and Blue staining cells can be determined. When greater than 10% of cells stain orange a term fetus can be expected.[21]

Gluck [21A] noted that the fatty acids composition of lecithin in the amniotic fluid resembled that found in lecithin obtained from fetal lung effluent, gastric aspirates and meconium and differed from the fatty acids composition of lecithins from fetal skin, placenta and saliva. This data was used to suggest that lecithin found in the amniotic fluid originates from the fetal lung. He found that there was a surge in amniotic fluid lecithin at 35 weeks gestation which he felt was due to the appearance of lecithin in the alveolar space. Since lecithin is considered the major surface active agent in the fetal lung, a direct relationship was established between low levels of amniotic fluid lecithin and neonates that developed respiratory distress. Using thin layer chromatography, Gluck established values for predicting which infant would develop respiratory distress according to the ratio of lecithin to sphingomyelin in the amniotic fluid. A chromatogram where the lecithin spot is clearly

greater than that of sphingomyelin is indicative of a mature infant with a mature lung and no respiratory distress will occur. With postmaturity, sphingomyelin will practically disappear and the chromatogram will show a very large lecithin spot with faint traces of sphingomyelin.

When placental insufficiency is suspected and positive clinical findings become evident and the accuracy of gestational age is confirmed by laboratory values, a 24-hour collection of maternal urine should be made for determination of estriol which has become one of the most widely used tests of placental function.[22] (Fig. 2) This

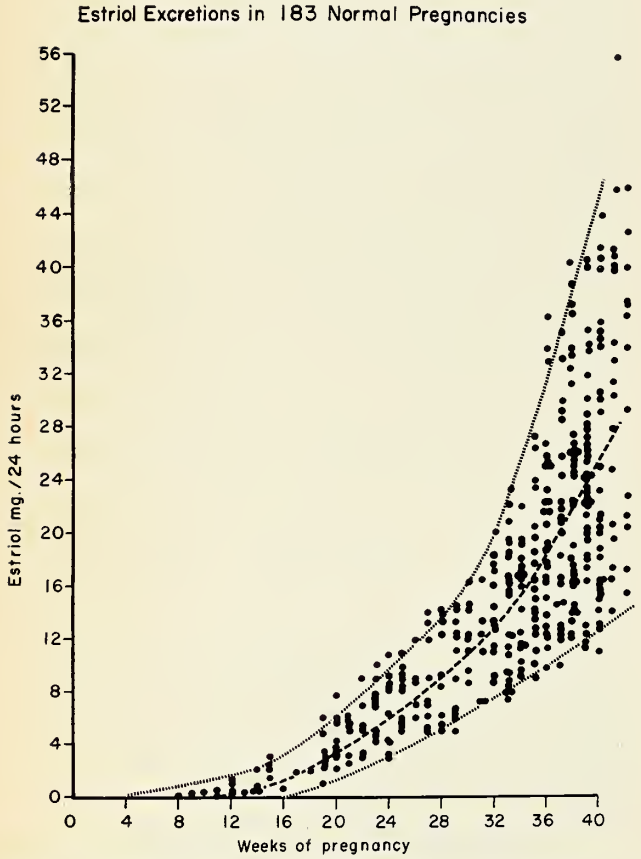


Fig. 2. Rising urinary estriol excretion in 183 normal pregnancies (From Scommegna and Chattoraj)[23].

hormone is produced by the fetus and the placenta as a unit. The fetal adrenal contributes the precursors in the form of androgens which are then converted to estrogens by the placenta and excreted by the mother. The amount of estriol excreted per 24-hours is found to increase steadily as the normal pregnancy progresses.[23] This rate of increase is greatest during the last trimester. Since both the fetus and placenta are necessary for the production of estriol a normal value attests to the health of both. Estriol excretion has been found to be low in cases of impaired placental function. It may occur in diabetes mellitus, erythroblastosis and toxemia. Various congenital abnormalities have also been related to decreased estriol excretion. In a pregnancy complicated by an anencephalic fetus the level of excretion is often one-tenth of the expected value found in a normal pregnancy.[24] Rate of placental blood flow is a determinant factor in materno-fetal interchanges. The maternal vessels supplying the placenta must be considered when evaluating the status of the fetus. It has been demonstrated by placental angiography that poor flow to the placenta resulting from inadequate and delayed perfusion forebodes a bad prognosis for the fetus.[25] This diagnostic technic is particularly useful in pregnancies complicated by toxemia and diabetes mellitus when maternal vessels are frequently spastic, or narrowed by angiosclerosis or calcification. (Fig. 3 & 4)

Meconium stained amniotic fluid while not being confirmatory of fetal distress appears to be associated frequently with placental insufficiency and chronic fetal distress. The color of the amniotic fluid can be evaluated both by amniocentesis or by amnioscopy, a technic described by Saling.[27] With the use of a conical-shaped endoscope using a conventional or fibre optic light source the amniotic sac can be visualized through the minimally dilated cervix.

In cases of prolonged pregnancy where the 24-hour excretion of estriol is low, or where angiography reveals poor placental perfusion or where meconium staining of the amniotic fluid is found, termination of the pregnancy is indicated. The situation is more serious when all three elements are present. The perplexing question now arises as to how to end the pregnancy. A difficult induction and prolonged labor puts the life of an already severely compromised fetus at stake. In such a case Cesarean-section may be the only method available for delivery. This dilemma may be resolved by a direct determination of fetal metabolic reserve which can be accomplished by a fetal tolerance test or "trial induction."[28]

Utilizing a small amount of oxytocin infused intravenously the relationship of uterine contractions to the regularity of fetal heart rate is measured. Hon[29] and Caldeyro-Barcia[30] have shown that late deceleration of the fetal heart rate, following a uterine contraction, where the lowest rate occurs 30-60 seconds after the peak intensity of the contraction suggests placental insufficiency. Change in the heart rate noted has

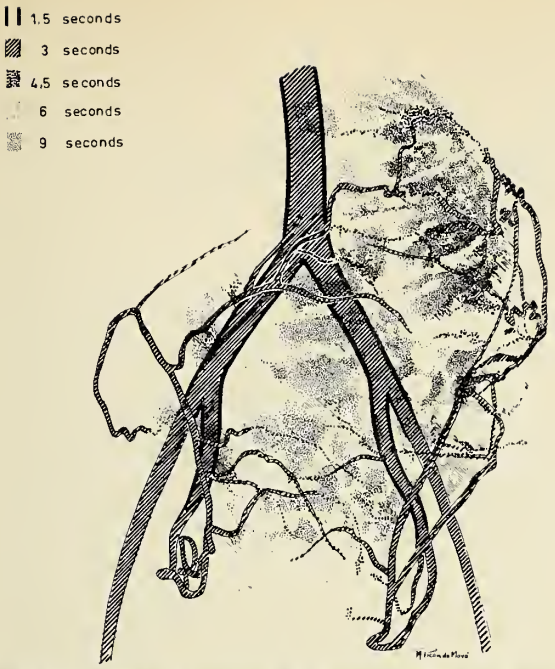


Fig. 3. Schematic drawing of a placental angiographic perfusion study demonstrating normal placental perfusion. Note preferential perfusion of uterine arteries and enlarged ovarian arteries with multiple entries into the intervillous space. (Bieniarz, J., et al)[25]

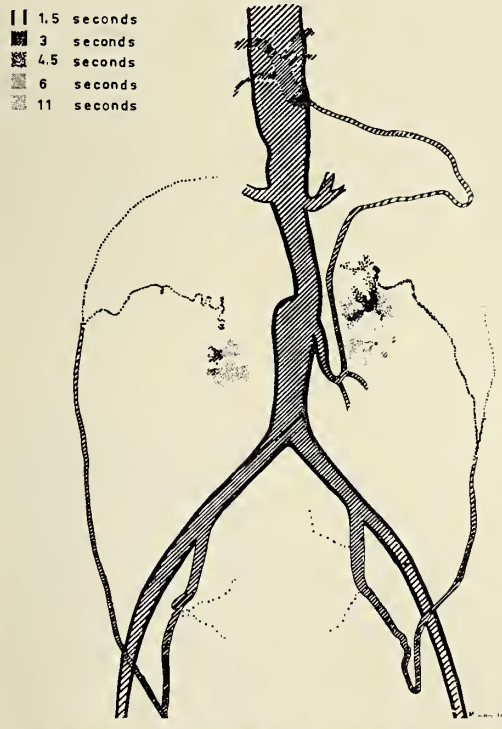
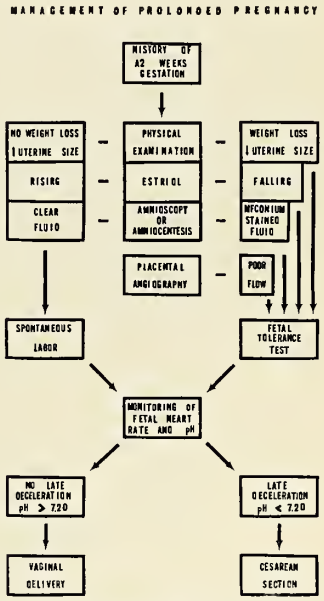


Fig. 4. Schematic drawing of a patient with poor placental perfusion. Here blood flow is primarily through the enternal iliac arteries. The uterine arteries are thin with few entries into the intervillous space. (Bieniarz, J., et. al)[25]

been termed a Type II dip or the pattern of utero-placental insufficiency (U.P.I.). The fetus is hypoxic and comes to rely upon anaerobic metabolic pathways. The acidosis that results from the provocation of uterine contractions produces a depression of the fetal myocardium. Finding of utero-placental insufficiency as reflected in the fetal heart rate pattern will encourage the obstetrician to deliver this patient by Cesarean-section.

A direct measurement of the acid-base status of the fetus prior to or during labor can be accomplished following rupture of the membranes by obtaining a sample of fetal blood and analyzing it for pH, PO_2, PCO_2, and base deficit. Fetal pH has been found to be the most accurate parameter. A Saling amnioscope is applied against the presenting part of the fetus, usually the head. Utilizing a pre-set scalpel blade, 2 mm. in depth, a small incision is made in the fetal scalp and a drop of blood, usually no more than 0.2 cc., is collected in a heparanized capillary or polyethylene tube. The normal range of fetal



Fg. 5. Suggested management of prolonged pregnancy.

pH is 7.25-7.35. If a value of 7.20 is obtained or if the pH appears to be falling rapidly with repeated samples, fetal metabolic distress is confirmed and the fetus should be delivered immediately.[27]

With the use of fetal scalp sampling and continuous monitoring of the relationship between uterine contractions and fetal heart rate, the increased risk to the fetus of a prolonged pregnancy can be accurately evaluated and properly

(Continued on page 607)

Diagnosis and Treatment of

Common Bleeding Disorders

By Joseph A. Caprini, M.D., M.S., and E. S. Kurtides, M.D., F.A.C.P./Evanston

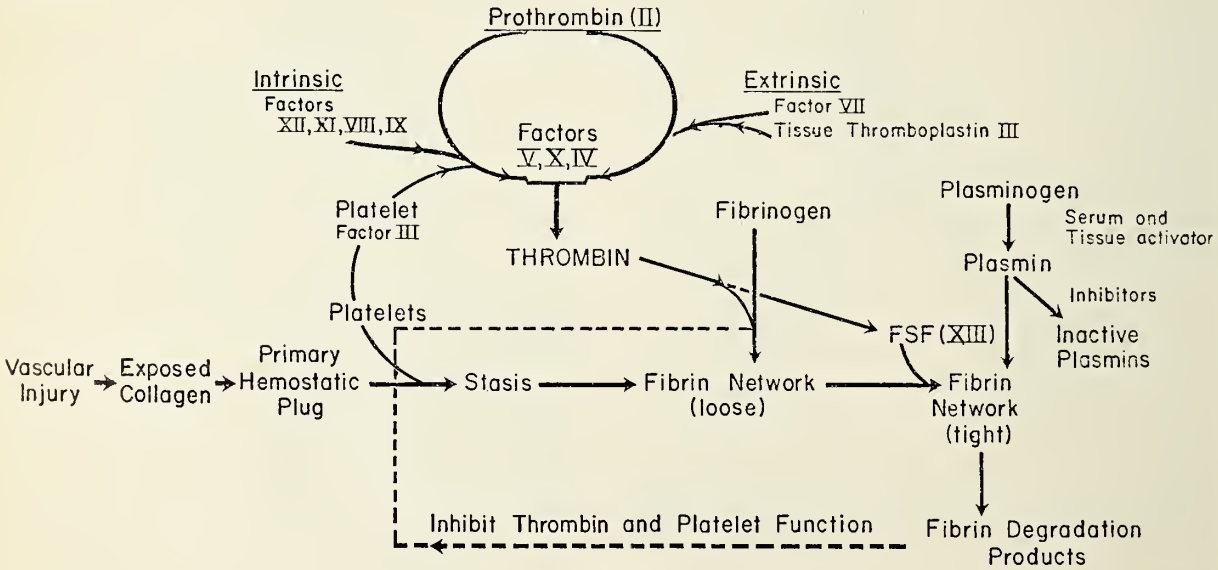
The prompt identification and successful treatment of coagulation defects require a thorough understanding of hemostatic mechanisms, diagnostic tests, and therapeutic modalities. This paper is designed to review current concepts and includes a schematic diagram to illustrate these mechanisms and their interrelationships (Figure 1), as well as a tabulation of pertinent data relative to the diagnosis and therapy of common bleeding problems (Figure 2).

The process of hemostasis may be divided into several stages: reflex vasoconstriction; formation of the primary hemostatic plug; intrinsic and extrinsic generation of thrombin; formation of the fibrin network.[1]

When trauma occurs, localized vasoconstriction ensues in the injured area, platelets adhere to exposed collagen at the site of the injury,[2,3] undergo changes in shape (viscous metamorphosis), and extrude granules containing a variety of chemical moieties. These substances include serotonin and epinephrine,[4] which apparently function to enforce local vasoconstriction and, possibly, initiate platelet aggregation as shown in vitro.[5,6] Acetylcholine esterase also is liberated, which assists in obliterating any vasodilatory component at the site of injury, while platelet factor III,[7] a released phospholipid substance, enhances the intrinsic generation of thrombin. Platelet clumping is influenced by high concentrations of adenosine diphosphate (ADP) found in the contents of extruded platelet granules.[8] Released platelet factor IV, bacterial products, leucocytes, granulocytes, and endotoxins cause platelet aggregation in vitro and are postulated to initiate intrinsic thrombin generation.[9,10] The final result of these interactions is the formation of a fragile primary hemostatic plug.

The generation of thrombin is the central process of blood coagulation and is the result of reactions in two interrelated systems. The extrinsic system usually occurs extravascularly, where tis-

Figure 1.



sue thromboplastin (III) combines with factor VII (stable) and reacts with calcium (IV), factor X (Stuart) and factor V (labile), resulting in the conversion of prothrombin (II) to thrombin.[11] This is a minor pathway as illustrated by patients with the hemophilia disorders who bleed excessively despite the presence of an intact extrinsic system.[12] The major pathway is the intrinsic system, which occurs intravascularly and involves a cluster activation of factor XII (Hageman), XI (PTA), VIII (AHG), and IX (PTC), followed by the final common pathway reactions (X,V,IV), with the generation of thrombin from precursor prothrombin (II).[13] The exact mechanism of in vivo activation of this system is unknown, although many surface and chemical substances will initiate it in vitro.[14]

The thrombin produced from these reactions induces platelet aggregation, is autocatalytic, and can participate in the activation of the fibrinolytic system by the conversion of plasminogen to plasmin. Its primary role, however, is the cleavage of the complex polypeptide fibrinogen (MW 330,000) into fibrin monomers.[15] The majority of these monomers rapidly polymerize into fibrin polymers by end-to-end linkage (urea soluble) and finally undergo extensive crosslinking as a result of the action of activated factor XIII (fibrin stabilizing factor).[16] A urea insoluble, solid, stable hemostatic plug results as a final product of these complex chemical interactions.

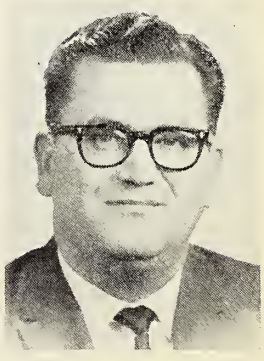
A delicate balance exists in the body between these hemostatic forces and the process of fibrin dissolution (fibrinolytic system). Plasma and tissue contain proenzymes, termed plasminogens, which are converted to active plasmins by various serum and tissue activators such as urokinase and streptokinase.[17,18,19,20] Trauma which causes cellular damage is one means by which this reaction can be triggered. Many factors are important in the plasma activation of this system, although the exact details currently are obscure.[21] Plasmin is a powerful enzyme which has the ability to affect the degradation of fibrinogen, fibrin monomers, and fibrin polymers. These split products tend to inhibit fibrin formation and interfere with the action of thrombin on fibrinogen. Additionally several types of fibrinolytic inhibitors occur and function to carefully balance the process of clot dissolution.[22,23,24,25]

Diagnosis

Evaluation of the patient must begin with a careful inquiry concerning bruising and bleeding from past trauma, tooth extractions, and other surgical procedures that might indicate a bleeding tendency. Examination for the presence of petechiae, ecchymosis, hemangiomata, spider nevi, hepatosplenomegaly, and lymphadenopathy should be pursued in all cases.[26] Vascular participation in hemostasis is poorly understood, and tests to adequately measure this phase are not available. The application of a tourniquet to the upper extremity (Rumpel-Leeds test) and observation for petechiae represents a technique that may be useful if gross abnormalities are present. It also has been postulated that the bleeding time reflects to some extent the integrity of this vascular component of hemostasis. Many vascular disorders have been described, such as hereditary hemorrhagic telangiectasia, and numerous non-thrombocytopenic purpuras. Coagulation changes are usually not present in these obscure conditons and the symptomatology is ascribed to defects in the vascular wall. Treatment is non-specific and includes vitamins, hormones, steroids, and other compounds, depending upon the severity of the process.[26,27]

The laboratory investigation of bleeding problems begins with a complete blood count, including evaluation of platelet number and morphology on the peripheral smear. The Ivy bleeding time, if properly done, can provide a great deal of information regarding the status of the primary hemostatic plug. A standard lancet puncture is made on the forearm with 40 mmHg of stasis provided by a blood pressure cuff, and the blood absorbed with filter paper without touch-





Joseph A. Coprini, M.D., M.S., (left) is clinicol ossistont in surgery ot Northwestern University ond Senior Resident in Surgery, Evonston Hospitol. After receiving his M.D. from Hohnemonn Medicol College he took his internship ot Evonston Hospitol ond o residency ond mosters degree in Surgery ot Northwestern. His speciol interests ore in bleeding problems ond thrombotic disorders os well os oxygen rocer studies, ond experimental pulmonory insufficiency.

E. Stephen Kurtides, M.D., (right) is ottending ot Evonston Hospitol ond others os well os ossistont professor of medicine, Northwestern University Medicol School. His proctice is limited to internol medicine, hemotology ond oncology. He received his M.D. from the University of Soloniko, Greece. Dr. Kurtides hos been involved in severol reseorch studies in erythrokinetics, the onemio of uremio, onemio of rheumotoid orthritis os well os bleeding disorders. In oddition, he is president-elect of the Hellenic Medicol Society of Chicogo ond on the Evonston School Coucus.

Figure 2.

The Diagnosis and Treatment of Common Bleeding Disorders

J. A. Caprini, M. D.
E. S. Kurtides, M.D.

Coagulation Mechanism	Test	Result	Disorders	Therapy
Vasoconstriction	Bleeding Time	Long	Telangiectasia	Estrogens?
	Tourniquet Test	Positive	Purpura	Steroids?
Primary Hemostatic Plug	Bleeding Time	Long	Thrombocytopenia	
	Platelet Count	Low	Idiopathic Thrombocytopenic Purpura	Splenectomy
	Clot Retraction	Defective		
	Platelet Adhesiveness	Decreased	Systemic Lupus Erythematosus	Steroids
			Drugs, Tumors	Withdraw Drugs
	Platelet Aggregation	Impaired (Variable)	Decreased Function	
			Glanzman's Thrombasthenia	Fresh Whole Blood
			Thrombocytopathia (congenital and acquired)	Platelets
			Aspirin, Dextran	Withdraw Drugs
			Uremia	Dialysis
			Combined Defect	
			Von Willebrand's Disease	Factor VIII Source
Thrombin Generation				
Intrinsic (Blood)	Partial Thromboplastin Time	Prolonged	Factor Depression	
Factor XII (Hageman)			Hemophilia A (VIII)	Cryoprecipitate
Factor XI (PTA)			Hemophilia B (IX)	Factor Concentrates (II, VII, IX, X)
Factor VIII (AHG)				
Factor IX (PTC)			Factors II, VII, IX, X Low	
→ X (Stuart)			Coumarin Therapy	Whole Blood or Plasma
→ V (Labile)			Liver Disease	Factor Concentrates
→ IV (Ca++)			Vitamin K Deficiency	Vitamin K
			Antithrombin	
			Heparin	Protamine
			Endogenous	Treat Underlying Disease
Extrinsic (Tissue)	Prothrombin Time	Prolonged	Factor Depression	
Factor VII (Stable)			Liver Disease	Bank Blood or Plasma
Factor II (Prothrombin)			Coumarin Therapy	Factor Concentrates
			Vitamin K Deficiency	Vitamin K
Fibrin Formation	Fibrinogen Level	Decreased	Congenital Hypofibrinogenemia	Fibrinogen ?
	Thrombin Time	Prolonged	Dysproteinemia	Plasmapheresis
Fibrin Stabilizing Factor (XIII)	Urea Solubility	Soluble	Fibrinase Deficiency	Bank Blood
Fibrinolysis	Clot Lysis	Shortened	Severe Liver Disease	Epsilonaminocaproic Acid?
	Euglobulin Lysis	Shortened	Prostatic Surgery	
	Fibrin Split Products	Positive	Intravascular Coagulation	Heparin ?
Disseminated Intravascular Coagulation	Platelets	Depressed	Abruptio Placenta	Fresh Whole Blood
	Fibrinogen	(Variable)	Shock, Trauma	Treat Underlying Cause
	Factor Levels		Infection, Burns	Antibiotics
	Fibrinolysis	Increased	Transplantation	Immunosuppressive Agents
				Heparin ?

ing the cut. Time required for bleeding to stop is recorded and the test is repeated until two values one minute apart are obtained.[28] Clot retraction is too variable in our experience to be helpful in acute bleeding problems.[29] Platelet adhesive index is time-consuming and subject to many factors that alter results.[30,31] Platelet aggregation is a major development in this field but usually is not required as an emergency screening procedure.[32,33]

Platelets may be reduced in number as a result of a generalized process such as systemic lupus erythematosus, neoplasms, or drug therapy.[34,35] Thrombocytopenia may result from massive blood loss, a consumptive coagulopathy, or an unknown cause (idiopathic thrombocytopenic purpura).[36] The introduction of platelet aggregation has resulted in the elucidation of a large group of diverse functional disorders.[37,38] Defective platelet aggregation with absent clot retraction is characteristic of congenital Glanzman's thrombasthenia, while thrombocytopathia (defective platelet factor III, normal clot retraction, variable aggregation) has been shown to

occur in a variety of disease states. Von Willebrand's disease is characterized by a prolonged bleeding time, reduced platelet adhesiveness and lowered factor VIII level; however, the exact nature of this congenital disorder is unknown.[39,40,41] Fluctuating measurements are common and problems may arise when surgery is undertaken in patients with this malady.[42] Diminished platelet function may be observed following dextran or aspirin therapy,[43,44] as well as in association with systemic fibrinolysis secondary to severe liver disease or intravascular coagulation.[45]

Thrombin generation, the central process of coagulation, can be quickly measured by good screening tests. The tissue system is evaluated by the prothrombin time (PT), where a source of tissue thromboplastin is combined with the subject's plasma, the clotting time recorded and compared to the results obtained with a control plasma. The presence of adequate levels of factors VII (stable), X (Stuart), V (labile), IV (calcium), and II (prothrombin) is required to achieve normal test values.[46] Most commonly, abnormal values are seen in patients receiving the coumarin compounds.[47] The intrinsic system may be evaluated by performing the activated partial thromboplastin time (PTT). A substance (celite) that activates factor XII (Hageman) is combined with a source of platelet phospholipid-like material (Inosothin). This mixture is added to plasma, time of clot formation recorded and compared to the clotting time of normal plasma. All plasma factors except platelets and stable factor (VII) are evaluated by the PTT. The principal value of this test system is the detection of the hemophilia states: [48,49,50]

Hemophilia A	Factor VIII (AHG) deficiency	Classical Hemophilia
Hemophilia B	Factor IX (PTC) deficiency	Christmas Disease
Hemophilia C	Factor XI (PTA) deficiency	Rosenthal's Disease

It should be remembered that Vitamin K deficiency, coumarin therapy, and liver disease involve suppression of factors II, VII, IX, X and affect both thrombin generating pathways. In order to fully evaluate the effects of these states, one should include both tests (PT, PTT) in the screening routine.[51]

The low factors can be further defined by the addition of aged serum (deficient in factors V and VIII) or adsorbed plasma (deficient in factors II, VII, IX, X) to the test system.[52] Individual factor levels now can be obtained with modifications of these systems that incorporate appropriate deficient substrate plasmas.[53,54,55] These tests also may be prolonged if a circulating anticoagulant is present as a result of certain disease states, including the collagen diseases, or during heparin therapy.[56] Substances which interfere with the action of thrombin can be detected by using a mixture of control and patient plasma in the PT or PTT test systems. The clotting time will markedly shorten if a deficiency exists; however, little or no correction results if an antithrombin exists in the patient's plasma.[57]

Fibrinogen levels may be measured in many ways, including assays of protein in a formed clot,[58] reaction with concentrated thrombin, where time is dependent on the amount of fibrinogen present,[59] immunologic identification, and heat precipitation.[60] We have found the latter method to be a rapid, reproducible test in acute bleeding problems. A capillary tube of citrated plasma is heated to 56°C. for three minutes, centrifuged for five minutes, and the precipitate measured, which consistently reflects the level of circulating fibrinogen. Determination of the integrity of the fibrin network may be grossly evaluated by adding a fresh clot to 5M urea solution and observing it for 24 hours. Lysis will not occur during this time unless a severe deficiency of factor XIII (fibrinase) exists or increased fibrinolytic activity is present.[61] Congenital factor XIII deficiency has been a cause of delayed bleeding and wound healing following surgery.[62] Observation of whole blood clot formation and dissolution (Glass clotting time) gives useful information regarding the fibrinogen level and overall fibrinolytic system, but lacks sensitivity.[63] Adding dilute thrombin to the patient's plasma and timing the clot formation is a more accurate test, particularly in emergency situations. A prolonged thrombin time may reflect a low fibrinogen level, the presence of fibrin degradation products, or a circulating anticoagulant such as heparin.[64]

The euglobulin lysis time, which is thought to measure plasminogen activators, is a widely used test for fibrinolytic disorders.[65] It is done by adding the patient's plasma to acidic water, reconstituting the resultant precipitate with buffer, and clotting this solution with calcium or thrombin. The time required for the clot to lyse is recorded and compared to normal plasma prepared similarly. Theoretically, when both activators and inhibitors are proportionately increased, the whole blood lysis time remains normal but the

euglobulin clot lysis time will be shortened, since it is not sensitive to inhibitors. Plasminogen activation is the primary reaction in the euglobulin system, and values may be falsely normal when plasminogen levels have been depleted during a fibrinolytic episode. The test is difficult to perform when factor levels are reduced to the point where clot formation is poor. We feel, therefore, that this test is of limited usefulness in the investigation of acute bleeding problems.

The addition of thrombin to normal plasma usually produces a substantial clot, plus serum containing little or no fibrinogen or fibrin-like molecules. Proteolysis creates fragments of fibrinogen and fibrin which remain in the serum since they clot slowly or not at all. The FI test, staphylococcal clumping, tanned red cell hemaglutination inhibition immunoassay (TRCHII), immunoelectrophoresis, and immunodiffusion on agar plates have all been used to detect split products in serum with fibrinogen-containing plasma as a control.[66] These techniques reflect important changes in the fibrinolytic system and at least one determination of this type should be included in the evaluation of every bleeding patient.

Intravascular coagulation is a pathophysiologic mechanism of growing importance, involving intravascular contamination by tissue thromboplastin-like substances which produce thrombi.[67,68,69] The process may be self-limited and of a low-grade nature or widespread and fulminant. Severe bleeding can result by depletion of plasma factors, platelets, and fibrinogen. Activation of the fibrinolytic system almost always occurs in response to intravascular clotting and may aggravate the bleeding diathesis due to the antithrombic effect of fibrin degradation products and further depletion of fibrinogen levels.[70]

Abruptio placenta, severe burns, shock, trauma, neoplasms, extensive surgery including transplantation—all may involve intravascular coagulation. Hematologic changes are variable, although most cases should reveal the characteristic depression of platelets with abnormal platelet forms on the peripheral smear. Low fibrinogen, prolonged PT and PTT values are present, as well as evidence of enhanced fibrinolysis (shortened euglobulin lysis time and positive serum fibrin split products). Platelet and plasma factor levels can be normal or even elevated, depending upon the severity of the process and the ability of the organism to respond to a consumptive challenge.[71,72] Consequently, intravascular coagulation may be present without bleeding or obvious consumptive process. Increased fibrinolytic activity (primary fibrinolysis) can uncommonly occur following prostatic resection or in association with severe liver disease. Platelet numbers and morphology may be normal, hypofibrinogenemia is usually present, but other factor levels are variable. Differentiation of these processes from DIC can be quite difficult and one should search carefully for evidence of intravascular coagulation, which is the most common cause of increased fibrinolysis.[73]

Treatment

Disorders of platelet function may respond to dialysis, drug withdrawal, splenectomy, or steroid treatment in cases of systemic collagen disease.[74] Viable platelets may be necessary and can be obtained by administration of fresh whole blood, platelet rich plasma, or platelet concentrates.[75] The storage of these components at room temperature has greatly increased the clinical useful half-life of administered platelets.[76] This allows adequate preparation for surgical procedures when difficulty is anticipated. Fresh whole blood and fresh frozen plasma are valuable in the correction of most factor deficiencies, regardless of etiology. Cryoprecipitate (rich in factors I, V, VIII) is useful for hemophilia A, while factor IX concentrates (also containing II, VII, X) are effective in the control of bleeding due to specific disorders such as hemophilia B, Vitamin K deficiency, liver disease, and coumarin therapy.[77] Protamine can be employed to reverse the effects of heparin administration. Bank blood or plasma lack platelets and factors V and VIII, but may be valuable for correction of other deficiencies.[78]

When evidence is present to suggest intravascular coagulation as the cause of bleeding, maximum effort should be employed in the elimination of the underlying disorder: evacuation of the uterus in abruptio placenta; appropriate antibiotics and surgical drainage when sepsis is apparent; operative intervention in cases of trauma, with attention to appropriate replacement of hemoglobin levels, platelets, and plasma coagulation factors. Heparin therapy may improve or correct the bleeding diathesis but should be employed only as a secondary measure after all efforts have been made to eradicate the primary process.[79,80]

Fibrinolysis may predominate but will usually subside with the correction of the intravascular coagulation. The use of Epsilon-aminocaproic Acid (EACA) under these circumstances to block fibrinolysis may be harmful to the patient who is relying on thrombolysis to maintain vascular patency during an episode of widespread clotting. Cautious administration of these agents in cases of severe liver disease (cirrhosis; post-portacaval

(Continued on page 601)

Licensure and Credentialing Of Health Manpower

By Morton C. Creditor, M.D.
Executive Director, Illinois Regional Medical Program

The following testimony was presented to the Health Care Licensure Commission.

Delivery of health care in the state of Illinois is conventional, and therefore suffers the conventional problems. Virtually all care available to those who can afford to pay for care is provided in the individual, private practice-oriented, fee-for-service system. By definition each component of care is separately served up by an independent entrepreneural enterprise. As medical services become increasingly specialized, the component parts increase in number, each as its own independent enterprise. Another aspect of conventionality is the emphasis upon sick care, rather than health care, both by the buyers and sellers of services.

Other conventionalities in Illinois include the fact that the majority of the poor, and near poor, receive their care in a different system than the one I have just briefly described; and many rural dwellers have no system available to them at all. The latter situation may be applicable to some affluent people who are new to their community or wish to enter the system on Wednesday afternoon.

The other aspect of care in Illinois which is conventional is the inability to characterize it as good—or bad, since we are no further along than anyone else in defining quality of care. I can recite the same ugly statistics about infant mortality, longevity, venereal disease rates, etc., but they are indictments of certain aspects of our socio-economic condition, not evidence of quality of medical or health care. At the other end I can shout the usual praises about being the most medically advanced country in the world. It's easy, without the necessity to provide documentation.

On balance we have a pretty reasonable situation in Illinois if we think in terms of total numbers of health professionals. Furthermore, we are exceedingly well endowed in terms of our capability to produce health professionals with our unique concentration of medical schools, almost as many as any other state in the Union.

The health care delivery problems encountered by the citizens of Illinois include the following:

1. Many cannot gain access to care because the component parts of the system of care are irregularly distributed throughout the state.
2. Increasing numbers are finding access limited by the increasing cost of care even when available.

Let me expand on these phenomena, which from the point of view of the citizen consumers represent the nub of their problems. I am speaking of entry into the existing system—the private, entrepreneural system of care. Entry into the system which you and I who are employed, insured, and relatively affluent enter. Really the only system available to us who are the advantaged in the State of Illinois. The usual entry into this system is by way of a physician—most often one engaged in what is generally referred to as primary practice—a general or family practitioner, general internist or pediatrician.

Now the facts are that as of this date there are many areas of this state in which there are *no* such entry points into the conventional system of care. There are 100 counties in this country with no physicians. The Illinois ratio of physicians to population is about 134/100,000 at last count, fairly good when compared to the remainder of the country; but Johnson County had only 16.4/100,000 at last count, Pulaski only 22.2 and an area on the south side of Chicago that I know of has only two physicians for 35,000 people. That is about 6/100,000. When the data are presented on a town by town basis it appears even worse since large numbers of communities in Illinois have no doctors. In these areas large numbers of people cannot easily gain entry into the conventional system of care.

Furthermore, with respect to the conventional care system the situation seems to be getting worse even with widespread acknowledgment of

the problem and it will continue to get worse until we examine the reasons why it is bad. To use a medical frame of reference, diagnosis must precede therapy.

Doctor deployment follows the same socio-economic laws as all other aspects of our society. Our society is becoming increasingly urbanized and if the farmers are leaving the farms then it is unrealistic to expect that doctors are going to move in a direction opposite to the population tide. Similarly, if the middle class is abandoning the inner city for the suburbs, then the doctors who are also middle class will do the same.

We must add to this the fact that advances in medical science have resulted in more specialization with fewer doctors entering the primary care fields. Hopefully this tendency will reverse, but even the primary physician knows that he must have a minimal critical mass of resources, if he is to practice in accord with his capability, and a minimal colleague relationship if he is not to become professionally obsolete in this rapidly changing world. He will not venture alone where he is needed most because he knows he cannot do the job for which he is needed. Therefore, be it in the Chicago ghetto or the small towns of Illinois, the situation is deteriorating at an increasing rate as the few remaining physicians retire and die not to be replaced by others in the conventional system. We must find an alternative if people are to be served.

The other fundamental problem is that of the cost of care. Perhaps a better way of stating the issue is by reference to what we learn about the delivery of care as we examine the financing of care.

Putting money into the conventional health care system will not result in more health care. We cannot solve our problems simply by dollar infusion. Medicare and Medicaid taught us that the conventional system cannot increase its productivity. Dollars made available produced more inflation of cost of existing services than new or additional services. Furthermore, the increased effective demand which the inevitable universal health insurance will produce will further inflate costs, unless productivity is increased by the creation of viable and competitive alternatives to the conventional system. This by no means should be interpreted as a suggestion that we abandon the current system, for I have no proof that any alternative will be better—but we need alternatives and competition if only to serve as the incentive for the conventional system to increase its productivity.

I would like to tell you some of the alternative concepts being developed in Illinois and then outline how their success will be related to licensure and certification.

But first I must tell you about quality of care assessment programs. I mentioned earlier that a characteristic of the conventional system of care is the fact that no one can say whether it is good or bad. Nor could I, or anyone else, defend alternative systems as to whether they are better or worse until we are willing to set standards which can serve as the basis of measurement and comparison. The only way an innovator can allay skepticism and fear, including his own, is by using a measurable index to quality of care as the basis for common judgment. By quality assessment we mean: (1) prospective statement of standards in clear, quantifiable terms; (2) measurement of actual performance against those standards; (3) clear statement of what will be done with the findings. We and others are participating in or seeking to support programs which will result in these "score cards."

I go next to rural health programs. Following up on the reality stated earlier, we are working in areas where there has been willingness to take down the sign that says "we need a doctor in this town" and replace it with an attitude that we need health care in this town. We are looking at the health care problems of the community, the resources which are actually available, not those unrealistically wished for; and we are linking the resources together into a *system* of care which is the best fit for the community at issue. Such systems will generally have centers and satellites, but whether at center or satellite, there will be no compromise on quality. The satellite will serve as an outreach—the distant sensing device, the remote eyes and ears of the professional core; it will be staffed by new types of people, or old types in non-conventional roles; by people who are there; and who with proper training and retraining and appropriate use of telephone, television and transportation capability, can extend services to those who have none. I am talking about the retrained nurse who is a farmer's wife, the returned military corpsman, the physician's assistant, the well-trained community aide, the type as yet unthought of. They will *not* be individual entrepreneurs or free floating operators. They will be remotely placed components of a highly structured system.

They *will be* a new type of entry point into the system of care, serving as participants in a

large share of patient management. Their competency and the competency of the system of which they will be a part will be judged by a quality assessment program.

Furthermore, it is my contention that we will attract physicians into those communities which will serve as the core centers in such organized rural systems for here they will find professionally satisfying situations, professional colleagueship, the critical mass of resources which will permit them to practice according to their capability, and a sense of really contributing in fulfillment of a need without unreasonable personal sacrifice.

Another significant development is the emergence of the health maintenance organization as a new delivery form. I am aware of about 15 separate initiatives in this state, some of which my agency is financing, to create HMO's. An HMO is an institutional form which guarantees a full spectrum of comprehensive health services for a defined group of subscribers on a pre-negotiated prepaid capitation basis. In other words, the individual components of health care are brought together in a system. The buyer gets whatever care is necessary during the subscription period. The providers share risks among themselves and also share savings as their incentive. The organizational form provides the incentives for cost containment and the structure to permit innovation and systematic efficient delivery; etc. Health care is the stress, for in this system a sick patient is an economic liability and a well person an asset. Included as part of the HMO strategy is competition between HMO's and competition of the HMO with the existing conventional system, spurring the latter on to efficiencies which now do not exist.

Finally, HMO development is being encouraged in areas where conventional services do not exist. These areas I referred to earlier, particularly in the inner city. Although professionals cannot be attracted into the *conventional* system for the reasons stated, it is expected that they will be enticed by these new, exciting delivery concepts.

Other new approaches to delivery of care include Family Health Centers which embody some concepts mentioned above; triage activities in which emergency care is rendered more efficient by making use of new types of personnel in civilian life as has been the case in the military for many years; the state trauma system is a big "triage" operation.

All of these activities depend for their success upon the use of new types of people and altered roles for established types. Furthermore, the dynamics of these systems—the fact that they are dynamic—require flexibility in the use of people.

Licensure

I now come to licensure, certification and credentials. Inappropriate legislation on these issues can completely stifle these initiatives. We must not subvert the public interest in the process of protecting the public interest and I do not envy your dilemma as you weigh these matters. I would like to make some suggestions however, from the point of view of a physician and health care administrator; and I apologize for the naivetes which I will express as they relate to points of law and politics.

I am not aware of any solid evidence that licensure (of health professionals) functions in the public interest. We have examples of *unlicensed* practice of medicine, dentistry, and nursing in this country such as in the armed forces, public health service and veterans' administration; and some believe that they represent the highest quality of care. There is no evidence that physical therapy services differ in quality between states with and without licensure requirements.

On the other hand, my license to practice medicine and surgery is a license to mayhem if I were to practice surgery and furthermore, even my medical competency is not the same today as it was when I received my original license.

I am not advocating that we completely do away with licensure, but I do wish to downgrade it from its position of sacred cow. It has certain utility in giving us a handle on certain types of people, it does not assure quality and it can be extremely inhibitory to progress.

I believe that it would be unwise to extend licensure to the newly developing and yet to be developed health professions. Licensure should be limited to those categories of personnel (health professionals) who may during the course of their careers function autonomously, thus assuming independent and ultimate responsibility for their actions.

Licensure is a means of keeping a "handle" on such people. Knowing who they are, where they are, what they are doing. It should not be expected to do much more than this.

Using my criteria doctors, dentists, osteopaths, nurses, psychologists, etc., should be licensed; but

I would add, that in some circumstances they should be able to function without licenses, e.g., in the military or in similarly organized systems. By implication, I do not envision these newer types for whom I do not recommend licensure as functioning autonomously.

Furthermore, where licensure is deemed necessary, it should never serve as a barrier to entry into the system of any interested and qualified candidate. Its purpose is to bring people in, not to keep them out. The criteria for licensure should be limited to educational background, demonstrated performance in accord with predetermined standards and evidence of good character and stability. Factors such as citizenship, residency etc., are totally irrelevant. Health professionals are mobile and move in both directions—in and out of the state. Every impediment tilts the balance in the negative direction. By further implication, every effort should be made for uniformity of criteria between states in order that reciprocity becomes widespread.

Licensure, once granted, must not be a sinecure. There must be developed some method for re-evaluating eligibility in some meaningful way. I hope that developing quality of care assessment programs, by direct measurement of performance, will serve as that index of continuing competency.

If these do not come to fruition, then periodic relicensure is necessary. It should be based on genuine evidence of continued competency and might include re-examination for some. But it should be realistic and addressed to what the licensee actually does. To examine the 50-year-old pediatrician or psychiatrist in surgery is folly; and to examine any established practitioner in the newest aspects of molecular chemistry serves no purpose.

Now, about all the rest. The technicians, technologists, paraprofessions, associates and assistants now existent, those gestating and those still a gleam in the innovator's eye. All of those about whom I hinted who will participate in these alternatives to conventional practice and will be used to make conventional practices more competitive, and who will make it possible to provide more care for more people. I would handle all of these by broadening where necessary the delegatory capability of autonomous institutions, agencies, and practitioners.

Laws inhibiting the ability of hospitals and doctors to delegate responsibility should be amended. The case of Darling vs the Charleston Community Hospital Corporation clearly established the fact that the hospital, a licensee, has ultimate responsibility. Parallel action identifies the physician, also a licensee, as having such responsibility. I assume Health Maintenance Organizations, Rural Health Care Systems, Family Health Centers, as institutional licensees will also have ultimate responsibility. The law should permit them to exercise this responsibility by appropriate delegation of functions.

First, let me be more explicit and then use examples which relate to my earlier statements. I do not think we should license physician's assistants, physician associates, Medex's, emergency care technicians, lab or X-ray technicians or nurse practitioners. On the other hand, we should promote in every way possible the education and utilization of these people.

Hospital licenses are granted on the basis of competency or evidence of the likelihood of competency. This should include job descriptions for the various human functions to be performed, such description to include expected range of knowledge and skills, and frequently including educational requirements, and often, types of certification which would be additionally descriptive.

I have spent many unpleasant hours on the defensive as needed hospital units were threatened with closure because there weren't enough licensed nurses on duty to satisfy the law. It didn't matter that there were unlicensed nurses (who couldn't get licenses because they were not citizens; not because they were not competent) and licensed practical nurses in adequate numbers under supervision. There was no concern for the quality of care or the capability of those who were there to do the job, or the consequences of closing the unit.

I was involved in the creation of a triage system in a busy emergency room in which a well-trained nurse serves as traffic director, sorting out the urgent and critical, thereby getting them to appropriate care expeditiously while she handles the minor stable conditions, thus diminishing waiting time for the patient, just as she saves precious and scarce physician time. But what she does is illegal in the strictest sense on the basis of current licensure law.

It is estimated that in some HMOs about one-half as many physicians will be required for quality patient care as in our conventional system. Part of this is due to the expectation that the physician will be relieved of many of his conventional tasks and limit himself to those

(Continued on page 605)

Industry's Response to Nutritional Challenges

By R. E. Smith, Ph.D.
Manager, Nutrition Research, The Quaker Oats Company, Barrington

The following article was presented at the Fourth Symposium on Nutrition and Food Technology, March 29, 1972, Lake Shore Club, Chicago. The symposium was co-sponsored by the Illinois State Medical Society, the Chicago Nutrition Association, and the Institute of Food Technologists-Chicago Chapter.

I'm sure you are as convinced as I am that any abdication of each of our responsibilities—be it academic, public service, governmental or from the private sector—will eventually upset the social balance wheel and allow one voice to become too strong in relation to the others. So, if I read you correctly, you are asking "Where does the food industry fit into this picture, and will it act responsively?"

I cannot speak for the whole industry. What follows is a paraphrasing of responses that are being made by various industry spokesmen.

For perspective, I'd like to start with the statement that the food industry, as a group, is not bent on getting rich quick at the expense of the consumer. Like any other industry, it exists because those it serves and the society it is a part have given it a license of sorts to do so. That license can be revoked if misused, and so any company that wants to be in business another 50 or 100 years would be foolish not to recognize that its long-term interests and those of the consumer are similar. This is where the food industry fits in to provide goods and services desired by the consumer.

Mr. Ken Mason, who as Group Vice President-Grocery Products heads our domestic grocery products business of more than $450 million annually, summed up the industry/consumer relationship this way: "One of the saddest phenomena on the American business scene today is the way we have let consumer activists, government agencies and a whole host of other not-very-well-informed critics plant the idea in the public's head that there's something over here on one side called business . . . and there's something over here on the other side called the consumer . . . and that the interests of one are quite different from the interests of the other. Nothing could be further from the truth. In fact, the most important single factor in the success of the American economic system over the years has been its *consumer orientation.* Businesses that know how to first *discover* and secondly *satisfy* genuine consumer needs and desires are successful in this country, and there are scores of examples to prove the point."

Concluding his talk to the Grocery Manufacturers of America, Mr. Mason said: "What is the manufacturer's responsibility to the consumer? It simply underpaves this point, that responsibility in business means just what the word says—the ability to respond accurately to the consumer. Businesses that do, win public favor and are successful; businesses that don't, find themselves in trouble not only with their critics, but with their consumers."

The recent widespread awareness of nutritional needs has prompted a hurried, somewhat superficial response on the part of industry to these nutritional challenges. There is a tendency on the part of some companies to respond to today's pressures in the wrong way and for the wrong reasons. In many cases the food industry has found itself pressured by probably well-intentioned but too often ill-informed persons or groups. And in the absence of a unified pro-



Dr. Robert E. Smith is manager of the Nutrition Research Department of the Quaker Oats Co., Barrington. He is a graduate from McGill University (BSc, MSc) and the University of Illinois (PhD). Dr. Smith is a member of the American Institute of Nutrition, the Canadian Nutrition Society, the Federation of American Societies for Experimental Biology, the Institute of Food Technology and the American Health Foundation.

fessional voice on these issues, some changes have been made which may not be totally sound from a nutritional point of view.

I'm not saying we shouldn't listen to critics. On the contrary, in those cases where consumer activists are accurately representing the needs and desires of consumers, they serve as extremely valuable lead indicators for business, as valuable as a company's own research department. But as in the case of a company's own research department, we must be careful not to assume that these people are always right.

Getting back to changes that are currently taking place on the food scene, let's talk for a moment about the development of fabricated foods. This activity has increased in importance, however, subtle changes in nutritional composition have occurred, which, when viewed on one product and by one company at a time, have had little impact on nutrient intake. The potential total impact on nutrient intake can be large with the potential changes in the variety of new products being manufactured.

Another example of this is what we in the industry call the "vitamin horsepower race." We all know, of course, that it theoretically is necessary to provide all the MDR's for only vitamins in a single product.

There also may be some cases where the food industry has inadvertently contributed to potential nutrition problems, particularly when new products have taken the place of staple dietary items. But just as industry may have helped to create some of these problems, so is industry the place where the problems can *best* be corrected. Once there is an awareness of a problem, it can be solved responsibly by industry, without unnecessary government intervention. My experience working with industry scientists and *executives* is that they are determined to do just this.

In order to maintain a high level of confidence in the food industry and have it prepare itself for the challenges that are upon it, I propose the following 10-point program.

1. List Corporate Principles

Our world today is very complex and there is much conflicting information. In order to meet its social responsibilities and under these circumstances, a company must formally develop a set of corporate principles to guide it in all aspects of its business and its relations with its customers, employees, shareholders, vendors, suppliers and government.

The next important step for facing the nutrition challenge is to formulate a concise nutrition policy.

2. Elaborate Nutrition Goals

It is imperative that a corporate nutrition policy be written and publicized. Not only does such a document specifically state what position nutrition will play in corporate decisions and define the nutritional goals of the company, but it publicly binds the company to objectives that can be avoided easily if no outside pressure is exerted. It also provides a clear means of communicating policy to those who implement programs.

The policy statement should address itself to such subjects as nutritional philosophy, honesty in packaging and labeling, responsibility in advertising, and consumer education.

A product-by-product description of nutritional goals is impossible, but broad groupings of food types can be described easily and nutritional goals for each stipulated.

3. Admit Responsibility

An important factor in meeting the challenge of nutrition is for industry and individual companies to admit they have a major responsibility to deliver sound nutrition to their customers. The U. S. freely boasts the highest standard of living in the world, brought about through our private enterprise system. Industry readily accepts the accolades, and so by the same token should assume responsibility for many of the negatives that have resulted from the industrial revolution—for example, pollution of the environment, waste of raw materials, misuse of human resources, and so on. Of most immediate importance to those of us in the food industry, of course, is the problem of malnutrition in the United States. There is evidence that the food industry is intent upon solving this problem, including what they have supported: the Family Assistance Act of 1970, the expansion of food stamp programs, nutritional education programs, nutrition guidelines asked for by FDA, and dozens of other individual and industry actions.

It is further up to those in the nutrition field to make the necessary advances in scientific knowledge and strive for a greater awareness and understanding of nutrition among manufacturers, consumers and even governmental agencies.

While we all recognize that modern food manufacturing has improved the overall sta-

bility and nutritional profile of some foods, it is our job to remind food processors that they *can* process out nutrients by removing various components of grains or other foodstuffs, with the objective of greater stability and eye or taste appeal. Processors must be shown that nutrients can be rendered less available through extruding, heating, freezing, chelation, oxidation, reduction, enzymatic treatment, and storage. They must be assisted in the areas of advertising and promotion to insure that accurate and nutritionally sound information is being used regarding food value, nutrition and health/benefit claims. They must be encouraged to seek new ways to improve food acceptability without altering taste and acceptability standards for foods by inclusion of inordinately high levels of sucrose, flavors and non-nutritive additives. They must be motivated to develop products utilizing fat stable systems of a more beneficial nutritional profile, and their help must be solicited for research in the areas of trace element needs in nutrition.

4. Designate a Department of Nutrition

A strong nutrition department is absolutely essential for a food company preparing to face the nutritional challenges of this decade. It must be staffed with competent people, have a certain degree of autonomy and be permitted direct access to responsible corporate decision makers.

The corporate nutrition department should: a) be responsible for drafting and implementing the company's nutritional policy; b) jointly approve all food projects; c) approve all food labels and be responsible for the accuracy of all nutrient statements on labels; d) participate in all decisions regarding all advertising, promotion and television commercials; e) share responsibility with Quality Assurance for the presence of all food additives, contaminants and foreign materials in foods; f) participate in basic nutritional research, attend scientific meetings, establish scientific contact with their peers outside of the company, and keep up with the nutritional literature; g) provide continuing nutritional education programs for the entire company.

The size and depth of this department would have to be determined by the individual needs of each company. The goals should be the same, however, regardless of the size of the company.

5. Evolve an Educational Program

One can provide all the nutrition in the world, but if your product isn't used, you've failed. Education is important as a part of the entire selling program.

In order to counteract the effects of half-truths and damaging information disseminated by some in the name of consumerism, industry must establish consumer education programs. These can take the form of ingredient and nutrition information on products, informational mailers, informative television commercials, television specials, support on independent educational projects, TV shows and various other approaches.

Programs to educate governmental agencies, though less visible, have a very important impact on the state of the nation's health. We accomplish this by replying in the most candid and concise manner to all the "Proposed Regulations" in the Federal Register which affect its business. This at least shows agencies like the Food and Drug Administration that we care and that we may have a different point of view than they. They should be told when we agree, too. Most importantly industry must back up all its arguments with facts when it does disagree.

A continuing education program for all company officials is also important, particularly if turnover is high, as it usually is in sensitive areas such as brand management.

6. Require Basic Research

The principal demand for research in the food industry is applied research. This is particularly true in the field of nutrition. Most companies regard basic research on nutrition as a luxury. However, to maintain competent nutritional expertise, it is desirable, if not essential, to allow nutritionists a small budget for basic research programs. It is also important that they be allowed to publish or in some other way gain recognition by their peers.

Despite the fact that applied research occupies the major portion of their duties, these nutritionists must be able to judge competent basic research, because they will undoubtedly be called upon to advise and select outside agencies to perform related research programs.

Examples of basic research which should be going on now include such areas as (a) finding ways to retain the desirable properties of polyunsaturated fats without suffering the oxidative rancidity inherent in present systems, and (b) determining exactly the trace element requirements for all ages of the human species.

7. Stay Profitable

All the good intentions in the world will be of no use if a company fails financially. While one's objectives should be to produce the most nutritious foods possible, there is still a place and time for everything. If a product won't be accepted by the public because of taste or cost considerations imposed by nutritional objectives, at the level of nutrition deemed optimal, the industry should settle for something slightly less. A growing awareness of nutrition and greater consumer knowledge is inevitable. These are factors which will be on the nutritionist's side.

8. Hasten Development of Management

I submit that each of us in the nutrition field, by living up to our own professional ethics and seeking to clarify the unknowns, can achieve a more responsive food industry by working with and advising food company executives at all levels. Each of us should strive toward this goal. Too, industry has a long tradition for training people to be problem solvers, and this can work even more to the benefit of society if they are turned loose on solving social problems outside the company. There are examples of this at work today in the food industry. Programs have been developed for loaning executives to urban projects and having others work as volunteers in their spare time to assist minority businessmen. These programs have the effect of serving society and at the same time providing fulfillment for the individual. This approach should be given high priority in every company's operations.

9. Inaugurate Information Systems

As mentioned under education, it will be imperative that industry inform the public about its products and itself. In order to do so, industry will have to know all it can about every product it makes. That means introduction of a sophisticated analytical program that will monitor not only known essential nutrient levels, but, also the undesirable substances in our products such as PCB's, mercury, aflatoxins, pesticides, and you name it.

10. Partnership With Public Relations

Last, but not least, to meet the challenges of the future we must work closely with those in our companies who are responsible for communications—between the company and consumers; and vice versa, the company and government; the company and the general public; and the company and its employees. Most often, these communications people are assigned to a company's public relations or public affairs department.

In order to deal effectively with all audiences on matters related to nutrition—and many other matters, of course—the public relations staff must associate itself closely with the Nutrition Department, the legal department, the Quality Assurance Department, and many other staff departments.

These, then, are the 10 areas I think industry should explore. Many companies are already quite far along this path. Summarizing, the 10-point program:

List Corporate Principles
Elaborate Nutrition Goals
Admit Responsibility
Designate a Department of Nutrition
Evolve an Education Program
Require Basic Research
Stay Profitable
Hasten Development of Management
Inaugurate Information Systems
Partnership With Public Relations

You will note the letter of each heading collectively spells *leadership*. This is what it's all about. The food industry has traditionally been one of the most efficient and innovative of all industries. It has been a leader in providing quality products and good values to consumers at reasonable prices. To maintain its leadership in the area of nutrition, the food industry will have to recognize the points as outlined and there is every indication this is being done right now. ◄

Nutrition Papers Available

Reprints of the papers presented at the Fourth Nutrition Symposium are available through the Illinois State Medical Society, 360 N. Michigan Ave., Chicago, 60601. There is a charge of $2.00 per copy for persons who did not attend.

The Future for Long Term Care

By Bertram B. Moss, M.D./Chicago

The following is based on the keynote address to the Illinois Providers of Long Term Care in Springfield, May 24, 1972.

We must re-evaluate a system that easily produces medical indigency when an adult child tries to finance the needs of his elderly parents. The public wants health care accessible when and where they want it, at a cost they can afford; but, in reality, only professionals or sophisticated consumers can evaluate the quality of the care delivered. Our intent is to provide what we feel is the best care for old persons. "Intent" is the key factor in the delivery of long term care; the "intent" of the institution sponsor, the administrator, the staff, the state, the old person, and society. We all seek the common ground to satisfy mutually satisfactory good "intents."

Long Term Care involves not only the approximate 5% of the over 65 population who need inpatient care, but also the 95% who require the psycho-social components of medical services in their own community. The public must be educated about the current dilemma of the ubiquitous aged who are already 10% of our population. Our own old age experience may someday be benefited if we can successfully meet the needs of the current elderly. Our own chances of eventually being institutionalized are not very great and the possibility of being truly "senile" is very small. The greatest probability is that we will live out our old age in the general community, if our needs can be successfully anticipated and provided for. The health and ecology needs of those few old people who need long term care facilities must be properly provided for as soon as possible.

A change is needed in national as well as state priorities to focus on the human needs of our old people. The Federal Government must share their resources for defense, foreign assistance and space priorities with the needs of our elderly, and implement a workable national policy for their care. Everyone involved must accept responsibility for the preventive, maintainative, restorative, medical and para-medical care required for all old people. Medical responsibility demands that all old people have a physician answerable for the quality and quantity of medical care and health environment delivered to them wherever they are.

Health care must be provided to everyone as a matter of entitlement, and with the fee-for-service system abolished for the poor. To qualify for post-hospital health care services based on specific diagnosis, or predetermined time for recuperation, is discriminatory, and totally ignores understanding that old people respond to illness or injury in highly individualized ways based on their specific physical and mental status as well as their reaction to the trauma. The complacency of society concerning those faced with growing old should be shaken by the fact that the depression and suicide rate is at its peak between 55 and 65 years of age, and continues at a high rate among the elderly.

Psycho-social services for the elderly, as part of the professional team approach, are of equal importance to medical service. True concern for the well and disabled, or impaired elderly, must include realistic maintenance, restoration or creation of individual self-esteem. This can only be accomplished by adequate funding for evaluation, treatment and related components of good care within achievable goals of individual capabilities, either in or out of long-term-care facilities.

The major scientific problems of clinical gerontology and general understanding of the aged still continue to confound us. Gerontological research continues in its effort to differentiate aging from disease and to understand the aging process and our reactions to aging. We must separate the problems of the few aged who are institutionalized from the greater majority who are not. Psychiatry has not yet taught us how to handle the guilt and hostilities of those individuals unable to cope with the problems of the aged, or of aging. Professionals can

Bertram B. Moss, M.D., is Clinical Director of the Division of Gerontology at the Chicago Medical School, and Co-ordinator of Health Services for the Council of Jewish Elderly of the Jewish Federation of Metropolitan Chicago, as well as Executive Director of Park View Home.

no longer put off dealing with the problems of the confused elderly, those soon to die, and those who live too long.

The plea of concerned professionals should be for relevant, conservative, confirmed studies of the aging and their relationships to the rest of society. We must be motivated only by sincere, truly scientific multi-disciplinary studies by all physical and behavioral scientists. It takes great strength to combat the trend to simply warehouse every person with a dependency need, and to repeatedly attempt a medical solution to diseases we cannot cure as yet. It takes equal strength to not over-utilize diagnostic and treatment procedures when their only indication is to be defensive from unsophisticated critics. At some point, gerontologists must admit that disease and death are inevitable; and that the resources for health care of the elderly are exhaustible.

We must constantly strive for support to expand existing programs to the large number of elderly and chronically ill persons who can benefit in their own homes. A new and better world cannot always be built simply by first tearing down what has been erected in the past. New changes from old must first be able to substantiate their worth as being better. If we are going to insist on change or on higher standards, then we must be willing to experiment and pay for them. Current options include outreach services, mobile health centers, homemaker services, expanded home health care, day care centers, group living arrangements, and subsidization of families to take care of their elderly in their own homes.

The gerontologist is characterized by his concern and activity for the well-being of the elderly and by his courage to stand against the tide in their support. A gerontologist is not a person who just sells something to old people. The plight of millions of our aged demands immediate recruitment of more professionals capable of innovative and creative approaches, and devoid of the emotional blocks which prevent empathy with the elderly. Illinois can boast of having the most medical schools producing and exporting the largest number of physicians; but Illinois woefully lacks medical resources for geriatric training, research or demonstration. There are many separate projects being developed to eventually benefit the old people, but leadership is needed to correlate the composite.

The bandwagon of a popular cause is already rallying; the politician, in particular, senses the impact of befriending 10% of his franchized constituency.

Recruitment of professionals of all kinds in gerontology must be our first order of business. We can teach staff to understand and work with old people, if they have sincere love for the elderly and a mature ability to look upon them as of equal status. For anyone, including a department of state government, to permit less than fully qualified and accredited persons to be responsible for old (or mentally ill) persons, is to only demonstrate the true value they place on our aging (or mentally ill). To have professional and supervisory staff on premises of our long term care facilities only during the normal 40 working hours of the week is unthinkable. Old people have earned the basic right to enjoy and choose the quality of life or death consistent with our gratitude for the invaluable contributions they have made to the development of our society. No one can defy the physiological processes of aging, but the choices of the elderly must be evaluated in terms of their ability to truly make their own decisions for their self-interest.

The multi-faceted problems and rapidly changing status of those already institutionalized precipitate frequent crises, making it impossible to categorize any aged individual as needing one specific "level-of-care" for any great length of time. Every old person has a unique combination of physical, social, and mental deficits, with an individualized response to the perception of his own problems. Comprehension of these processes is essential in dealing with the elderly.

All health planning for the elderly must be based on the professional judgments of those familiar with their needs, rather than remote theorists far removed from the problems, or those stimulated only by self-serving or profit motivations. As the single largest overall consumer representative of long term care, the state is in position to purchase the care it needs. As the single largest provider of funds for long term care, the state is also in position to qualify the care needed. The system and the specialized experience needed requires highly placed, experienced, persuasive professionals with academic and experience credentials to cross over the various agencies. Inter-agency task force administration is already making operable the ideas of the creative specialists, as well as beginning to control quality and performance. Such cross-over also will ensure sophisticated restraint in accepting or plagiarizing any current alternative

vogue without pilot study or trial. The State of Illinois must have its own professional talent who may also seek private consultation or studies to guide them. Any method for reimbursement is self-defeating in a system dedicated to enhancing excellent programs of care, if facilities providing the most effective programs are penalized through their efforts to reduce dependency among the elderly. Retrospective "medicare-type" cost reimbursements must be eliminated and a prospective rate scale substituted as an incentive formula for a facility based on actual costs of proper services delivered. Only this method assures the proper incentive to the facility for ongoing efforts in upgrading and strengthening such programs. A formula based on evaluation of the needed services would encompass consideration of not only the services delivered, but also the capital expenditures necessary to provide those services with ongoing re-evaluation. The state, as provider for one-half of all recipients of long term care, must not sanction a system that requires the proprietary institution to be forced to make a profit only by diminishing care and services. All payment techniques must also be interpreted and applied so as to promote, rather than restrict, home health services without any institutionalization as a prerequisite.

Profit is an ugly word, if it is the prime consideration relating to human welfare and safety. Profits made after delivery of good care for the aging are needed to both sustain our lavish economy and maintain the luxurious amenities of modern life. While the profit is being reaped by some, the non-profit group could well be designing the ideal models for long-term-care, and the innovative and creative programs for future progress.

Long-term-care facilities have learned that public aid does not always pay for the minimum services demanded. If the state buys only the cheapest service at the lowest level of care, there will be no higher quality service. We know that the state pays premium rates for elderly persons in hospitals and state mental hospitals who really belong in less expensive long term care facilities.

This is the propitious time for change! The White House Conference on Aging has drawn public and political attention to the needs of the aged. We can only get quality services for the aged if the major proprietary and non-profit facilities, plus the agencies dealing with poor people, are all motivated to really deliver and finance care of which we can be proud.

Proprietary versus non-profit operation or sponsorship, of long-term-care facilities, has frequently been debated. History of acute short-term general hospitals has witnessed a full turnabout from predominantly proprietary to non-profit. The seeming inevitable national health program may precipitate a comparable history for long-term-care facilities. The future will probably witness most of the needs of the elderly being met in their own homes. Health care will be provided by the hospital as home health care, and when needed, as inpatient care. The nursing home will provide the convalescent and/or rehabilitative care on a short-term basis. The home for the aged as we now know them, with public voluntary support, could be the permanent total-care home of last resort; with the admonition that no one should be permanently institutionalized if there is any alternative.

Illinois may not have to come up with more money if a high level partnership among federal, state and local government, private health insurers, and all health care providers solve the problems of inaccessibility of health services, manpower shortage, rising costs, waste and inefficiency, and lack of professional expertise.

Providers of long-term-care are unable to police all the facilities as long as membership in their own well motivated associations are voluntary. The licensing bodies will have to do the policing as well as setting the standards. Provisional licensing to permit future phase-out or correction of deficiencies will certainly be criticized if tragedy strikes in the interim.

In Conclusion:

The providers of long-term-care must not be constantly placed in a defensive posture. They are performing a needed service and if they do it with good intent they are to be commended. Self-appointed guardians of public interest often prey upon and intimidate institutions, with the help of guilt ridden, troubled persons compelled to expiate their painful inner emotions. Enforcement of standards by licensing bodies and voluntary associations, would avoid public scandals, and still guarantee compliance. This system may not sell newspapers, but it would upgrade the facilities, as well as protect and encourage good professionals to work in long-term-care institutions.

Profit making facilities are entitled to make money if they provide *good service.* Good service must be defined by competent, well motivated professionals. Voluntary facilities are entitled to be supported if they serve their intended purposes. The state, as consumer for one-half of the long-term-care recipients, and as the standard bearer for all of our institutions, faces a perplexing problem. The challenge for the future is to seek the means of providing high quality comprehensive social and health care to the elderly poor, without compromising services to the non-poor, within the confines of available public funds. ◄

investment corner

Year-End Tax Planning

By Lloyd A. Byerhof, Partner
Peat, Marwick, Mitchell & Co./Chicago

Individuals with high current or potentially high future income should pay careful attention to the income tax consequences of business affairs and personal investments prior to year-end. Higher income normally results in high income taxes.

Income tax planning has traditionally centered around a review of personal financial affairs near the end of the tax year, to time deductions and/or income in order to take advantage of tax rate changes or special tax provisions that might save taxes, e.g., purchase of property eligible for the investment credit. Although effective tax planning should become a year-round effort with all important financial transactions being reviewed for possible tax effects as well as economic effects, year-end tax planning can have an important role in an individual's affairs.

Year-end tax planning that concentrates on the timing of income or deductions must be done within the rules of the Internal Revenue Code. For a cash basis taxpayer, this can be relatively simple because income is realized for tax purposes when it is actually or constructively received. Whereas allowable deductions normally are deductible in the year paid.

Where there is a closely-held corporation involved (e.g., professional service corporation), such items as bonuses, commissions, profit-sharing contributions, and dividends can often be postponed or accelerated by appropriate corporate action.

Sales of assets also can be timed to give a taxpayer income or loss in the best tax year.

Timing of capital gains and losses to obtain maximum benefit from the 50% long-term capital losses reduction also is vital. Offsetting short-term capital gains against long-term capital losses may be desirable.

The maximum effective tax rate on net long-term capital gain in excess of $50,000 is now 35%. This results from the interplay of the 70% maximum individual income tax bracket and the 50% net long-term capital gains deduction.

Net long-term capital gains of up to $50,000 each year qualify for the maximum 25% alternative tax rate. Thus, for taxpayers in the upper income tax brackets, timing of long-term capital gain so that no more than $50,000 of such gain is taxable in any one year may result in considerable tax savings.

Self employed individuals, including partners in certain partnerships, may want to consider adopting an H.R. 10 pension or profit-sharing plan before the end of the tax year. Such a plan can provide the vehicle for using pre-tax dollars to fund future retirement benefits. The amounts set aside in H.R. 10 plans can earn or grow tax-free until a person's retirement. The application and possible limitations imposed by the wage controls portion of the President's Economic Stabilization Program should be checked before adopting any H.R. 10 plan.

(Continued on page 601)

MIDWEST CLINICAL CONFERENCE

AND THE **ILLINOIS STATE MEDICAL SOCIETY ANNUAL MEETING** JOINTLY SPONSORED BY **CHICAGO MEDICAL SOCIETY AND ILLINOIS STATE MEDICAL SOCIETY** AND PARTICIPATING SPECIALTY SOCIETIES **MARCH TWENTY-FIFTH—TWENTY-EIGHTH, NINETEEN HUNDRED SEVENTY-THREE, CONRAD HILTON HOTEL, CHICAGO, ILL.**



Highlights of the Conference

ISMS House of Delegates

Annual President's Dinner

Public Affairs Breakfast

Scientific Sessions

PLAN TO ATTEND

the view box

Leon Love, M.D./Chairman/Department of Radiology
Loyola University Stritch School of Medicine

This patient is a 45-year-old female who had ongoing complaints of pain and stiffness in the neck; since we would rather discuss this case on the basis of its radiographic findings we will not give known clinical information.



Figure 1

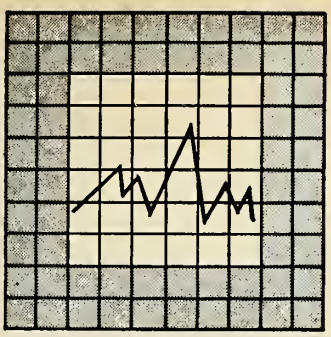


Figure 2

What's your diagnosis?

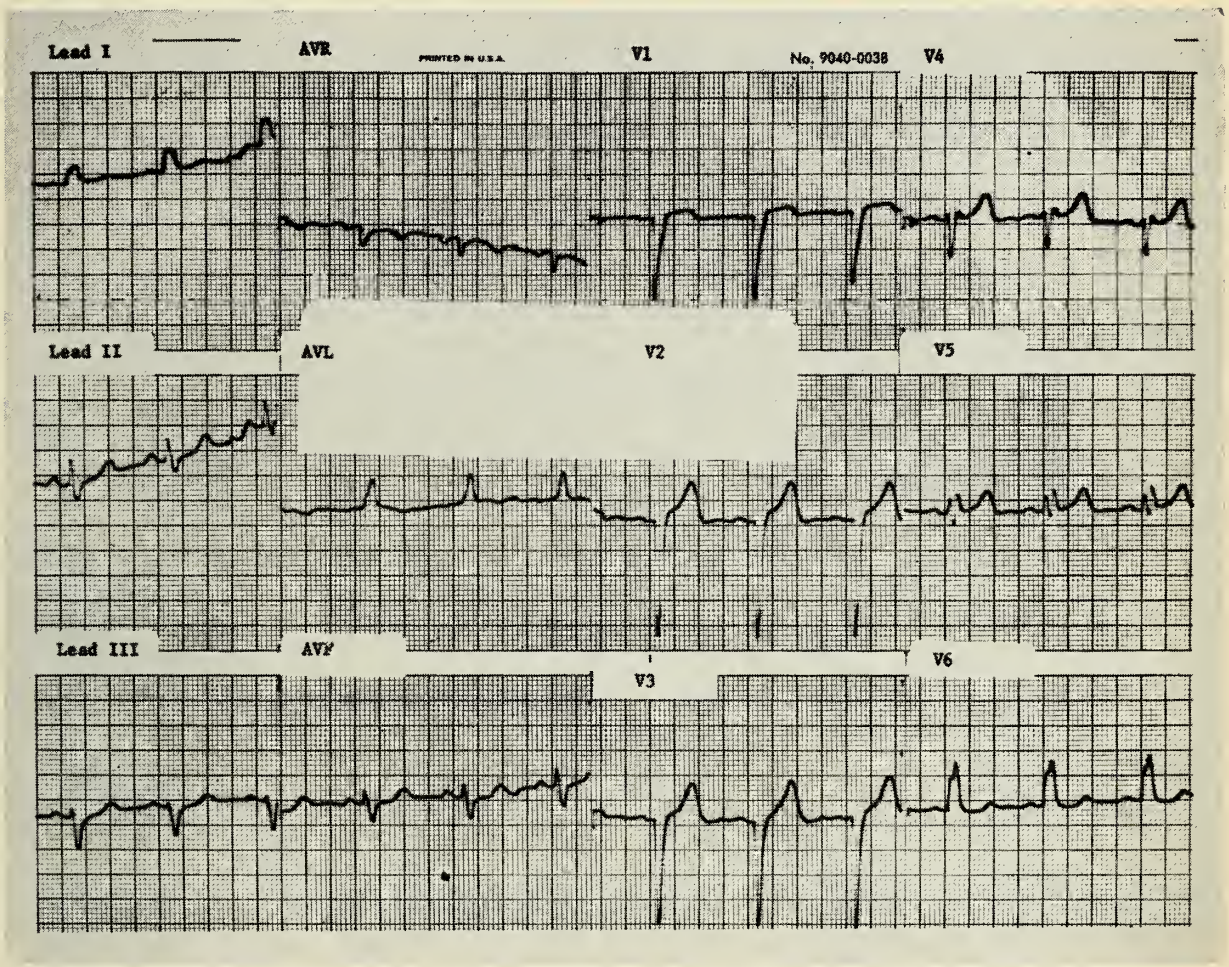
1. Osteoarthritis of the cervical spine
2. Disc pathology
3. Rheumatoid arthritis
4. Tuberculosis

(Answers on page 607)



ekg of the month

John R. Tobin, Jr., M.D., M.S., Rimgaudas Nemickas, M.D., Patrick Scanlon, M.D., John F. Moran, M.D. and James V. Talano, M.D./Section of Cardiology, Loyola University Stritch School of Medicine



A 65-year-old woman presented to her physician because of a three month history of chest pain brought on by using her vacuum cleaner. She also complained of the same chest pain when working in her garden. Her physical examination was normal. An electrocardiogram was taken.

1. The electrocardiogram shows:

A. Old anteroseptal myocardial infarction.

B. Left ventricular hypertrophy.

C. Typical left bundle branch block.

D. Wolff-Parkinson-White syndrome.

E. Left bundle branch block with primary T wave changes.

2. Which of the following statements are true?

A. The patient's exertional chest pain is compatible with a diagnosis of angina pectoris.

B. Her ECG is compatible with the diagnosis of ischemic heart disease.

C. The ECG is of no help in this case because there is a conduction defect.

(Answers on page 617)

Maternal Death Study No. 9

Edited By Robert R. Hartman, M.D./Jacksonville

This 37-year-old lady had delivered seven previous babies without any problems that she or her attending physician felt were of any importance. She had been seen at 4-6 week intervals during this pregnancy at the direction of her doctor. Approximately two weeks prior to her admission and two weeks subsequent to her estimated date of confinement, elective induction had been offered and refused—the patient thought it was best that "nature take its course."

She was next seen approximately four weeks after her estimated date of confinement and approximately two hours after the rupture of her membranes, she presented herself to the hospital where examination revealed a thick cervix which admitted a finger. She was having poor quality contractions occurring every 3-5 minutes.

When good quality contractions did not ensue spontaneously after approximately 14 hours, the nurse was ordered by telephone to start a "buccal pitocin induction." Tablets were given at irregular intervals—the second one was given 20 minutes after the initial dose, the third 30 minutes later, the fourth 10 minutes after the third, the fifth 20 minutes after the fourth, and the sixth 45 minutes after the fifth. Three minute contractions of good quality were now occurring and the patient was reported to be 4 to 5 cm. dilated. Greenish amniotic fluid was noted, and there was no record of fetal heart tones or blood pressure determinations from that recorded at the time of admission. Contractions were reported to be irregular and of poor quality throughout the afternoon and early evening. Approximately 24 hours after admission the patient was started on an infusion containing ½ cc. of pitocin (5 units?) in 500 cc. of 5% glucose in water at the rate of 20 drops per minute.

Following this, contractions occurred every 2-3 minutes lasting 30 seconds. However, there is some discrepancy of the record since it took almost 12 hours for these fluids to run and the patient was reported to have had "an uneventful night, sleeping most of the time." Approximately 36 hours after institutionalization; the intravenous was "increased to 16 drops per minute" and soon thereafter she complained of a headache and the intravenous was discontinued in 30 minutes. Six hours later she was complaining of chills and a foul discharge was noted. One hour later her temperature was 101.8, and and hour subsequent to this it reached 103. She was started on intravenous Cephalothin 1 gram in 1,000 cc 5% glucose in water administered over a period of an hour and 45 minutes. This was followed by 5% glucose in water, 250 cc. containing 10 units of pitocin. These fluids were given over a period of approximately 2½ hours, and no good quality contractions ensued.

After a febrile and intermittent night of sleep, another infusion containing one cc. (10 units?) of pitocin was given in ¼ liter of 5% glucose and water. X-ray pelvimetry revealed "a normal size pelvis with a single fetus estimated to be at term and to weigh 7½ pounds."

Four cm. dilatation was recorded at the time the patient was taken to the delivery room, and about 20 minutes later she complained of sudden chest pain and did not respond to stimuli. She was given external cardiac massage, mouth to mouth resuscitation, and cardiac adrenalin along with oxygen. She was pronounced dead some 20 minutes later, about 10 minutes after an agonal Cesarean section which produced a stillborn fetus weighing approximately 9 pounds.

A post mortem examination was done which revealed a recently incised uterus with a fibrinopurulent endometrial cavity. Endometritis leading to generalized septicemia was thought to be the immediate cause of death. However, microscopic examination revealed findings typical of amniotic fluid embolism. Other significant laboratory studies revealed a vaginal culture showing E coli, urine with a positive albumin and a few red cells. Hemoglobin, hematocrit, and white count were within normal limits for a patient in labor.

Discussion

There were several points of contention raised as this case was analyzed. The use of buccal pitocin for induction has been the subject of debate. The manufacturer suggests that it not be used

in patients over 35 years of age or in women who had had four or more children. In addition, it is recommended that the effects of the attempted stimulation be carefully monitored by competent observers present at all times, and that a rather rigid dosage regimen be closely followed. There are other contraindications and precautions, but these four were apparently ignored in the attempt to get this unfortunate lady delivered . . . that is, she was 37 years of age, she was gravida 8, medication was ordered by telephone and the stimulation was not carefully monitored. Fortunately, uterine rupture did not occur; but unfortunately labor did not ensue.

The necessity for emptying the uterus after the membranes have ruptured is likewise a controversial subject, but when clinical evidence of intrauterine infection is present, areas of disagreement are rapidly minimized. The significance of "greenish amniotic fluid" would indicate that apparently the fetus had passed meconium, an indication of some distress. While every obstetrician has seen healthy babies delivered following an uncomplicated labor two or three hours after meconium was noted in the amniotic fluid, most experienced observers view this finding with apprehension and as a warning the delivery should be effected reasonably soon. However, in this instance, repeated attempts at medical induction were continued over a period of 2½ days until finally some amniotic fluid was squeezed into a maternal uterine sinus with the above tragic results.

It was the opinion of your committee that this death came about as the result of an amniotic fluid embolism complicating the poorly supervised attempted induction of a grand multipara, whose situation was already compromised by evidence of intraterine infection. Someone has bemoaned the lack of a retrospectroscope, but it seemed to your committee that several cardinal principles were violated in this situation and that this patient's life might have been spared if any one of several courses had been followed:

1. If it had been possible to convince this lady that she did not need this, her eighth, pregnancy and some definite measure of family size limitation had been made available to her. Admittedly, there may have been religious reasons why this course was not available.

2. The uterus in an elderly grand multipara should *not* have been stimulated; but if it were stimulated, very careful observation should have been available to manage any problems that might arise.

3. The failure of the uterus to react to adequate stimulation should have signaled the necessity of a Cesarean section, preferably before but certainly after evidence of intrauterine sepsis developed.

It seems regrettable that both patient and doctor had not been sufficiently informed as to the importance of good prenatal care so that more frequent visits, particularly in the last trimester, could have led to closer observation. Your committee was forced to conclude that this death was directly obstetrical and that there were preventable factors primarily in the field of medical management. ◄

Twenty-Seven Children's Clinics in January

Twenty-seven clinics for Illinois' physically handicapped children have been scheduled for January by the University of Illinois, Division of Services for Crippled Children. The Division will conduct 20 general clinics providing diagnostic orthopedic, pediatric, speech and hearing examination along with medical social, and nursing services. There will be six special clinics for children with cardiac conditions, and one for children with cerebral palsy. Any private physician may refer to or bring to a convenient clinic any child or children for whom he may want examination or consultative services.

January 3 Hinsdale—Hinsdale Sanitarium
January 4 Lake County Cardiac—Victory Memorial Hospital
January 4 Sterling—Sterling Community Hospital
January 4 Effingham—St. Anthony Memorial Hospital
January 8 Peoria Cardiac—St. Francis Children's Hospital
January 9 Peoria—St. Francis Children's Hospital
January 9 East St. Louis—Christian Welfare Hospital
January 10 Joliet—St. Joseph's Hospital
January 10 Champaign-Urbana—McKinley Hospital
January 11 Macomb—McDonough District Hospital

(Continued on page 590)

Mrs. Robert Hart, Pulse Editor

From the President's desk...

My holiday message to you stems from the October Woman's Auxiliary to the American Medical Association Workshop I attended which was filled with information on legislation, education, and community action for health. Each individual was outstanding in his respective field, and each with his own new and innovative approach to the age old fact of giving a helping hand to a brother in this space age. Some of the guest speakers in attendance were doers while others were teachers, but all were contributing to a common cause.

I feel the Auxiliary is making an effort to reach out and let the world know that in all their actions and programs and unmarked deeds, spoken or accomplished, they attempt to answer "What is Brotherhood?" It is the wisdom of Lincoln and the warmth of Gandhi. It is the humility of Jesus, the humbleness of Mohammed, and the humanitarianism of Confucius. It is Catholic, Protestant, Jew, and Hindu living together in peacefulness while progressing. It is the people from each corner of the world, working side by side on a goal and pushing shoulder to shoulder in the work force and waiting in the union hall, school halls, political halls, and law halls for ways to advance the common good. It is the Ten Commandments and the Sermon on the Mount. It is the Bible, the Talmud, the Koran and the unwritten rules of the tribesmen. It is the wisdom of all ages and the word to describe it is "Brotherhood."

Still, in essence, to direct it to what it means to you personally, it is the understanding of friends who lament at your bad luck and delight in your triumphs. You cannot see brotherhood, nor can you hear or taste it. Yet you can feel it every day. It is the touch on the back when life looks gloomy. It is the smile of encouragement when the road seems difficult. It is the helping hand when the load becomes too heavy. That to me is the meaning of brotherhood. And ours is all under the guise of "Auxiliary."

Perhaps a little reminder will help for you to acknowledge these quiet words and rejoice in the thoughts and work well done over the years. May I add "A Happy Holiday . . . TO YOU ALL!"

Mrs. August Martinucci
President



CHICAGO MEDICAL SOCIETY WOMAN'S AUXILIARY volunteers pose with seven of the 12 new St. Joseph Hospital interns who have completed an orientation course for foreign medical graduates offered by the women at the hospital. Auxiliary volunteers pictured are: (l. to r.) Mrs. Joseph Shanks, Mrs. Mitchell Spellberg, Mrs. Herbert Cibul, and Mrs. Gustav Tufo.

Do You Know About Our Benevolence Fund?

Misfortune may come to any of us and the best-laid plans for security in old age often go to pieces when investments turn bad or people live far beyond normal life expectancies. That is why programs like the Benevolence Fund of the Illinois State Medical Society, providing as they do a *non-governmental* cushion against such disaster, are important.

The Benevolence Fund of ISMS was established in 1940, and the Woman's Auxiliary has played a major role in helping finance it. In 1971, there were 30 recipients, twenty-eight widows and two physicians. The monthly average payment for the entire group was about $5,515. No one but the members of the committee responsible for the fund ever knows who the beneficiaries are. No names are ever mentioned or made public and the work of the committee is always confidential. Perhaps a few illustrations, disguised as to preclude identification would help each Auxiliary member identify with a specific case.

A widow of a once leading specialist in Illinois came to the committee's attention. Her husband had died some 30 years previously, leaving a fairly substantial estate which should have taken care of her last year. However, she had lived far beyond the normal expectancy to well past 90 and her estate was exhausted. She was allowed the maximum benefit for the three years until her memory still protected her.

Another case, a widow of a well-known specialist who had a large practice found herself in difficulty because the investments on which she had depended to care for her had gone bad. The fund was able to care for her for some years until her death.

A different type of case was that of a young physician who developed mental illness while an intern, but went on, nevertheless, to establish a practice and join his county medical society. One year later the mental illness became acute and he had to be hospitalized for a considerable period, leaving his wife and two small children. The fund took care of him and his family for the year he spent in the hospital, and made it possible for him to be rehabilitated and return to his practice after he was much improved.

In still another case, a physician well over 80, retired because of arthritis, fractured his hip in a fall and needed long hospitalization. He was cared for until his death, and his widow, who was likewise helpless because of paralysis, then received the benefit until she died.

While a portion of the dues to the Woman's Auxiliary is allotted to Benevolence, it is not enough. Voluntary contributions are necessary and a wonderful way to remember friends, relatives, and associates is through a Memorial Fund Contribution.

Those interested in contributing should make their checks payable to: The Woman's Auxiliary to the Illinois State Medical Society (mark it *Benevolence).* Send your check to your County Benevolence Chairman (or County President), together with the name of the person remembered and full information telling where a card of your contribution may be sent, showing your name and address as donor. The Benevolence Chairman will forward your check and all information to me after she has made a record of her report. I will in turn send a card to the contributor and to the family or person to be notified of the contribution. I will then make a record for my report and send the check to the State Treasurer.

Contributions in honor of a person or persons are processed in the same way and cards are sent to the donor and recipient. Contributions from County Auxiliaries other than dues are handled in the same way and a card of thanks sent to the Auxiliary for their records.

The history of the Benevolence Fund is one of achievement which emphasized the importance of this program. It also emphasizes the willingness of the medical profession to take care of its own members, with its own funds, in a mutual insurance program. The contribution of the Woman's Auxiliary has been one of the greatest single factors in the operation of the fund; and I trust that the Auxiliary will never permit its interest to slacken in the years to come.



Mrs. Robert (Meinard) Kooiker, Benevolence Chairman

45th Annual State Convention
Woman's Auxiliary
March 25-28, 1973
Conrad Hilton—Chicago

Venereal Disease Today

Part II

Syphilis

By Dr. L. V. Tavs, Chicago Board of Health

This two-part series on venereal disease is presented as a service to the physicians in Illinois.

The first clinical sign of acquired syphilis is the chancre. After an incubation period which may vary from 8 to 90 days (usually about three weeks), the chancre appears at the site of the initial treponemal penetration. The chancre is usually a single, painless erosion with a sharp border, shows some degree of induration, and has a clean base with serosanguinous exudate. About 70% of patients develop painless, firm satellite lymphadenopathy after about one week. However, the initial lesion may be quite atypical, may be multiple, may vary in size from a few millimeters to 1-2 centimeters in diameter, and lymphadenopathy may be absent. A practical axiom is to regard any lesion on the genitalia or anal area as syphilitic until proven otherwise.

Classification of Stages of Syphilis

I. Acquired Syphilis
- **Primary**
 - **Seronegative, darkfield positive chancre**
 - **Seropositive, darkfield positive chancre**
- **Secondary**
- **Latent: No clinical evidence of syphilis except positive serology.**
 - **(Serology includes FTA-ABS test)**
 - **Early latent: Known duration of the disease four years or less.**
 - **Late latent: Known duration of the disease more than four years.**
- **Late**
 - **Includes cardiovascular, neurosyphilis, gumma of skin, mucous membrane, bone, liver etc.**

II. Congenital Syphilis
- **Early Congenital: Patient is 2 years of age or less.**
- **Late Congenital: Patient is over 2 years of age.**

While the external genitalia, cervix, and anal areas are the most common sites of the chancre, the primary lesion may occur elsewhere, such as the lips, tongue, tonsil, or finger. With or without treatment the chancre heals in 2-6 weeks, depending on its size and degree of induration.

Serous exudate from the lesion should be examined for the presence of Treponema Pallida using darkfield microscopy. The FTA-ABS (Flourescent Treponemal Antibody-Absorption test) is the first serologic test to become reactive, usually 3-4 days after the appearance of the chancre. The RPR (Rapid Plasma Reagin circle card test) and the VDRL (Venereal Disease Research Laboratory test) are usually reactive within 4-14 days (average 6-7 days) after the appearance of the primary lesion. If initial tests are negative, the serologic tests should be repeated at one week intervals for at least one month.

About 3-4 weeks after the appearance of the chancre (6-8 weeks after the infecting exposure) the secondary stage may appear. **The four cardinal signs are the skin eruption, mucous patches, condyloma lata, and generalized lymphadenopathy.**

The skin lesions are bilaterally symmetrical, and may be macular, papular, papulosquamous, or pustular, may be generalized or confined to sites such as the palms and soles or anogenital area. Moth-eaten alopecia beginning in the hair of the occipital portion of the scalp is charac-

Schedule for Treatment of Syphilis

Stage	Dosage of Benzathine Penicillin G
Primary and Secondary	2,400,000 units i.m. (½ dose in each buttock) and repeat in 1 week. Total: 4.8 million units
Latent	2,400,000 units i.m. (½ dose in each buttock) and repeat weekly for 3 treatments. Total: 7,200,000 units
Late	2,400,000 units i.m. (½ dose in each buttock) and repeat weekly for 4 treatments. Total: 9,600,000 units
Early congenital	100,000 units per kg/body weight given i.m. in one or two injections, or 400,000 units Aqueous procaine penicillin G per kg. body weight total dosage, to be given in 10 daily divided doses.
Late congenital	2,400,000 units Benzathine penicillin G i.m. once weekly for 4 weeks, or a total of 9,600,000 units.
	Penicillin Sensitive Cases
Erythromycin	Early: 500 mg. orally every 6 hours (2 grams per day) for 15 days. Total: 30 grams Late: 500 mg. orally every 6 hours (2 Gms/day) for 20 days. Total: 50 grams
Tetracycline	Early: 2 grams daily for 20 days. Total 40 Gms. Late: 2 grams daily for 25 days. Total 50 Gms

teristic. Papules in areas of moisture and friction, such as the intertriginous surfaces of the anogenital area, may hypertrophy to become condylomata lata.

Systemic manifestations occur in about 40-50% of patients, and include headache, sore throat, low-grade fever, muscle and joint aching, loss of appetite, and malaise. Focal areas of pain may occur over the skull or tibiae, representing small areas of periostitis and osteolytic involvement. There may be a specific rhinitis and transient proteinuria.

Among the rare manifestations of secondary syphilis are nephropathy such as transient syphilitic nephrosis (with marked proteinuria and prompt recovery following antisyphilitic therapy), and acute hemorrhagic nephritis (associated with gross hematuria, edema, proteinuria, and impaired renal function). Early benign syphilitic hepatitis presents diffuse liver tenderness, enlargement, mild jaundice, reduction in bromsulphalein-excretion and depression of other liver functions. There is prompt improvement following antisyphilitic therapy.

During the first year of untreated syphilis, early meningo-vascular or meningo-encephalitic involvement may develop, with severe headache, stiff neck, diplopia, convulsions, confusion, and spinal fluid findings of high cell count, high total protein content, and positive spinal fluid serology. Also, in the first year or two of untreated cases relapses on the skin or mucous membranes, iritis and irido-cyclitis, or neuroretinitis may show.

A diagnosis of secondary syphilis must be supported by laboratory evidence. As a rule Treponema pallida can be obtained from serum from any mucous or cutaneous secondary lesion and can be identified using darkfield microscopy. The diagnosis may be established without a positive darkfield if characteristic skin or mucous membrane lesions are present and the serologic tests are reactive. In the secondary stage serologic tests are reactive in all cases. With or without treatment the secondary manifestations disappear, and the patient enters the latent stage.

In the latent stage there is no evidence of syphilis except reactive serology, which should include a confirmatory FTA-ABS test in most cases. During latency there may be periodic showers of spirochetes into the bloodstream from foci in the liver or lymphnodes. The treponemes produce a transient spirochetemia as they migrate to a new site, and during such an episode a pregnant woman with untreated latent syphilis can infect her child in utero.

After adequate therapy for early syphilis, the serologic titer of non-treponemal antigen tests, such as the VDRL and RPR tests, drops sharply for 3-4 months, then levels off at a low titer level to become negative after 8 months to 2 years after treatment. Sero-positivity with low titer persists beyond 2 years in about 5% of primary syphilis and 15-20% of secondary syphilis following therapy. The FTA-ABS test is not influenced by therapy, and remains reactive indefinitely, often for the lifetime of the patient. ◄

Crippled Children's Clinics

(Continued from page 585)

January 11 Springfield—St. John's Hospital
January 11 Cairo—Public Health Department
January 12 Chicago Heights Cardiac—St. James Hospital
January 16 Rock Island—Moline Public Hospital
January 16 Quincy—Blessing Hospital
January 17 Evergreen Park—Little Company of Mary Hospital
January 18 Elmhurst Cardiac—Memorial Hospital of DuPage County
January 18 Decatur—Decatur Memorial Hospital
January 18 Rockford—Rockford Memorial Hospital
January 22 Peoria Cardiac—St. Francis Children's Hospital
January 23 Peoria—St. Francis Children's Hospital
January 23 Mt. Vernon—Park Avenue Baptist Church
January 24 Elgin—Sherman Hospital
January 24 Centralia—St. Mary's Hospital
January 24 Springfield—Pediatric-Neurology—Diocesan Center
January 26 Chicago Heights Cardiac—St. James Hospital
January 30 East St. Louis—Christian Welfare Hospital

The Division of Services for Crippled Children is the official state agency established to provide medical, surgical, corrective, and other services and facilities for diagnosis, hospitalization and after-care for children with crippling conditions or who are suffering from conditions that may lead to crippling.

Carrying on its program, the Division works cooperatively with local medical societies, hospitals, the Illinois Children's Hospital-School, civic and fraternal clubs, visiting nurse association, local social and welfare agencies, local chapters of the National Foundation and other interested groups. In all cases the work of the Division is intended to extend and supplement, not supplant activities of other agencies, either public or private, state or local, carried on in behalf of crippled children.

★

Specialized Service
IN
PROFESSIONAL LIABILITY INSURANCE
is a high mark of distinction

THE
MEDICAL PROTECTIVE COMPANY
FORT WAYNE, INDIANA

Professional Protection Exclusively since 1899

CHICAGO AREA OFFICE: T. J. Pandak, J. C. Kunches, and L. R. Gannon, Representatives
T. J. Hoehn, Consultant
815 Commerce Drive, Suite 102, Oak Brook, Illinois 60521 (312) 325-7314
SPRINGFIELD OFFICE: W. J. Nattermann, Representative
426½ South Fifth Street, Springfield 62701 (217) 544-2251

Doctor's News

PROFESSIONAL STANDARDS REVIEW ORGANIZATIONS (PSRO)—With the passage of H.R.1, provision has been made for Professional Standards Review Organizations consisting of practicing physicians in local areas. They will assume responsibility for comprehensive review of services covered by Medicaid and Medicare programs. Until January 1, 1976, only qualified physician-sponsored organizations can be so designated. After that, priority will be given to these organizations, but if they do not qualify or do not want to assume responsibility, HEW may designate another organization as the PSRO for the area. PSRO are to provide assurance that institutional services are medically necessary and are provided in accordance with professional standards. It could assume review of non-institutional care services.

Other chief provisions of H.R.1, include a substantial increase in Social Security cash benefits, increased benefits for many categorical persons, dental and optometric service coverage without a physician's order, chiropractic under Medicare, mandatory family planning services under Medicaid, child health screening, and waiver of requirement for registered professional nurses in skilled nursing facilities in rural areas. These are but a few of the many provisions of the new law. ISMS is analyzing this to determine how best to apply the new requirements in Illinois, and all physicians are encouraged to familiarize themselves with H.R.1.

PHYSICIANS OFFICES BEING CHECKED—Recent activity by the Bureau of Drug Licensing, Department of Registration and Education, has resulted in the spot checking of several physicians offices, unannounced, primarily in the northern Illinois area. Inspectors and investigators are auditing inventory records of drugs being dispensed, especially controlled substances, ensuring that samples are not being repackaged, that any aspirin-containing pharmaceutical and other potentially hazardous items are dispensed in child-resistant containers, that medication dispensed is labelled in accordance with regulations in the Pharmacy Act, that proper security is maintained, and so on. The investigations have resulted in warnings to some physicians about methods followed in dispensing. ISMS members who dispense are encouraged to familiarize themselves with all regulations regarding this activity to reduce any possible problem which might result from an audit.

STATE EMPLOYEE VOLUNTEER BLOOD DONOR PROGRAM—All state employees who are able to donate blood are being requested to join "The First Illinois Volunteers," an organization of state employees who have pledged to become blood donors when called upon. Fred H. Uhlig, chairman of the program, is optimistic since the initial response indicates 48.88% are willing to become volunteer blood donors.

Similarly, ISMS employees have volunteered at a 67% rate to become part of the Blood Brothers Program of the Metropolitan Chicago Blood Council. Action of the Board of Trustees has encouraged establishment of volunteer blood donor programs on a local basis throughout the state, with physician initiative in establishing these. Where programs already exist, physicians are encouraged to endorse and actively support them. While a blood shortage does not presently exist, predictions have been made that a famine situation could occur after publicity about the labeling requirements dies down.

PHYSICIANS IN THE NEWS—Margaret M. Scannell, M.D., was recipient of the Physician-of-the-Year Award presented by the Mercy Hospital Intern-Resident Alumni Association of Chicago. Dr. Scannel, the first woman physician to receive this Award, has been a pediatrician at Mercy Hospital for over 27 years.

For the first time, the board of directors of Mount Sinai Hospital Medical Center has elected two doctors from the medical staff to its board. Elected were **Leon H. Seidman, M.D.,** a member of the Department of Surgery and clinical assistant professor of surgery at the University of Health Sciences/Chicago Medical School; and **Irwin D. Horwitz, M.D.,** a member of the Department of Surgery and Otorhinolaryngology at the hospital and is professor of surgery and chief of otolaryngology at the University of Health Sciences/Chicago Medical School.

Neil A. Kurtzman, M.D., has been named professor of medicine and chief of the Nephrology Section of the University of Illinois Hospital and the Abraham Lincoln School of Medicine, Chicago. New director of Ambulatory Care Services at Rush-Presbyterian-St. Luke's Medical Center, Chicago, is **Edsel K. Hudson, M.D.** A leading pathologist, **Robert W. Wisller, M.S., M.D., Ph.D.,** has been appointed to the newly-established Donald W. Pritzker Professorship in the Biological Sciences at the University of Chicago. **Henri S. Havdala, M.D.,** has been named department chairman of the Division of Anesthesiology at the University of Health Sciences/The Chicago Medical School and Mount Sinai Hospital Medical Center. **Jacques M. Smith, M.D.,** has been named a vice president of the American Heart Association. Dr. Smith is chief of staff of Northwestern Memorial Hospital and associate professor of Northwestern University Medical School.

Dr. Welford Receives Medical Service Award



Dr. Norman T. Welford, senior attending physician in the Pediatrics Department at Community Memorial General Hospital, LaGrange, accepts the First Annual Medical Service Award from Patrick R. Grogan, President of the hospital's Associate Board. The Award was presented at the Associate Board's Annual Benefit Dinner-Dance where Dr. Welford was cited for his outstanding personal contributions of time and effort to his community. Dr. Welford is an associate professor of pediatrics at Rush Medical School and the Abraham Lincoln School of Medicine. He has been active in local, state and national medical societies and is a Fellow of the American Academy of Pediatrics.

Physicians Discuss Expansion Plans at Gottlieb



Discussing preliminary plans for expansion at Gottlieb Memorial Hospital, Melrose Park, at the annual Emerald Ball, sponsored by Gottlieb's Women's Auxiliary, are: (left to right) Dr. LeRoy Levitt, Dean of the Chicago Medical School; Dr. Caesar Portes, Medical Director of Gottlieb and past president of the Illinois State Medical Society; Dr. Frank J. Jirka, Jr., president of the Illinois State Medical Society and senior attending physician at Gottlieb; and Dr. Joseph Angell, president of the medical staff at Gottlieb.

Abstracts of Board Actions

(Continued from page 545)

New IDPA Billing Forms

At the request of ISMS representatives headed by President-elect Dr. Willard C. Scrivner, Governor Ogilvie directed the Illinois Department of Public Aid to develop a new, simplified billing form for physicians providing services to public assistance recipients. The new IDPA form will consist of a single sheet of 8½ x 11 paper on which the physician will be able to indicate in a precoded format, the services provided by him. In more than 90 percent of the cases, the only other information required will be date and place of service and the charge. IDPA sources say the new form will speed up processing of bills to allow payment in 30 days. The department is now processing 1,500,000 individual claims per month. The new form should be available by January 1, 1973.

Release of Charge Data & Fee Profiles From Third Parties

The Board approved a request from the Council on Economics & Peer Review that the council study the feasibility of ISMS developing its own current fee profiles. It referred back to the council recommendations regarding the release of charge data and fee profiles by third party payors for the use of peer review committees and foundations for medical care.

Illinois Regional Medical Program

Officials of ISMS, the Illinois Foundation for Medical Care and the Illinois Regional Medical Program have agreed to meet for discussion of subjects of mutual interest, especially in the area of quality care programs.

Hospital Emergency Service Regulations

County medical society officers and hospital chiefs of staff will be notified that by January 1, 1973, every hospital in Illinois must be a participating member of an areawide plan for providing general hospital emergency service. By July 1, all plans must be fully developed and operational. The ISMS Board of Trustees is urging physician participation and leadership in implementing the new rules and regulations developed by the Illinois Department of Public Health.

Support for County Health Departments

The Board of Trustees re-affirmed its support of county health departments and will publicly commend those communities sponsoring November referendums on the issue of state funding for county health departments.

Public Affairs Dinner

At the request of the Governmental Affairs Council, the Board agreed to eliminate the annual public affairs dinner from the 1973 annual meeting schedule and to broaden the scope of the public affairs breakfast sponsored the last few years by the Woman's Auxiliary.

Washington-Springfield Orientation

The Public Affairs Washington Roundup, March 4-11, will be expanded to include a five-day trip to San Juan, Puerto Rico. Details of the political-medical education-vacation will be announced soon. The Board also approved the concept of an ISMS sponsored state government orientation program for physicians to be conducted in Springfield, while the General Assembly is in session next year. Pending budget considerations, such program may be held in conjunction with a special meeting of the Board.

Legal Definition of Death

Although a definition of death has been devised by a special ISMS committee, the Board does not specifically recognize the immediate need to legislate a legal definition. The committee will continue its work in this area.

Laboratory Proficiency Testing

The Board has endorsed a questionnaire to be used by the Illinois Department of Public Health for identifying laboratories operating in physicians' offices. Approval is contingent upon the understanding that ISMS may review the survey results prior to any state action requiring proficiency testing. It is the society's understanding that it shall have the prerogative of reviewing any regulations developed by IDPH prior to implementation.

Recommendations for State Advisory Committee

ISMS will recommend physicians for appointment to two new state advisory committees established by the Poison Prevention Packaging Act and the Sudden Infant Death Syndrome Act.

Venereal Disease

The Board will request funds from the Educational & Scientific Foundation to distribute venereal disease control literature which is available free from various pharmaceutical companies. Action was taken on recommendation of the Council on Environmental and Community Health which reviewed and endorsed the material. The Board also agreed to forward to the AMA a resolution calling for increased public education in connection with venereal diseases.

Rubella Testing for Marriage Licenses

The Board expressed dissatisfaction with the recently passed bill on rubella testing but, because pending court action is expected to prevent implementation of the act, ISMS will not seek corrective legislation. However, it did direct legal counsel and the Governmental Affairs Council, if necessary, to review the current physician certificate used for premarital examinations with the intent of recommending changes in the wording to include testing for all venereal diseases, sickle cell screening, and possibly rubella immunity testing.

Health Care of the Poor

The following have been appointed to an ad hoc Committee on the Health Care of the Poor:

Drs. Dean R. Bordeaux, Peoria; Paul William Clark, Oregon; Alphonse Robinson, Mounds; and Alfred Klinger, Lawrence Hirsch, and Hugh S. Savage, Chicago. Drs. Fred White and Willard C. Scrivner will represent the Board as consultants to the committee, which expects to call upon the special knowledge and expertise of such individuals as Drs. Joyce Lashoff, George Spencer and Edsel Hudson of Chicago, and Dr. Robert Greifinger, Rock Island; Mrs. Sylvia Fox, ASPIRA; E. Duke McNeal, Chicago lawyer; Oliver W. Crawford, SAMA; Dr. William J. Roggers, Chicago dentist, and Walli Siddiq, Council on Bio-Medical Careers.

Unified Membership Promotion

The American Medical Association, the Illinois State Medical Society, and the Chicago Medical Society will share the costs of publishing and distributing a pamphlet explaining the benefits of unified membership.

Recommend Drug Labeling Amendments

On recommendation of the Council on Mental Health & Addiction, the Board endorsed in principle proposals to amend certain labeling requirements specified in the Pharmacy Practice, Medical Practice and Food, Drug and Cosmetics Acts. If a physician does not wish to have the drug name, strength, and quantity listed on a prescription label, present law dictates that he must so inform the pharmacist in writing. Proposed amendments to the aforementioned acts would allow the pharmacists to eliminate this information merely by the oral order of the physician. The matter was referred to the Governmental Affairs Council.

Waiver of Liability for Hepatitis

ISMS will urge the Governor's Task Force on Blood to have legislation introduced to extend the waiver of liability in hepatitis cases beyond July 1, 1973.

Pilot Arbitration Program

In an effort to develop alternatives to the existing system of litigating medical malpractice claims, the Board approved regulations for use in establishing a pilot arbitration program in 1973. It was pointed out that an arbitration program could speed up handling of claims, save time of doctors, witnesses and lawyers, assure a greater degree of fairness in the decision process, minimize the likelihood of frivolous appeals, eliminate publicity, and reduce the amount of judgment established by emotion or theatrical appeals to a jury. Lower awards are not guaranteed.

New Insurance Program Approved

The Board approved a program of business overhead expense insurance recommended by the ISMS Insurance Committee. The plan to be offered to ISMS members is designed to pay the physician's usual and customary business expenses incurred during periods of total disability from accident or illness which last more than 30 days. Expenses covered are rent, electricity, heat, water, laundry, employees' salaries, and monthly pro-rata share of contributions, membership fees, and depreciation on furniture and equipment.

Acupuncture

Because of the increasing interest in acupuncture, the Board directed the Governmental Affairs Council to draft legislation to control this procedure, which is not mentioned now in any Illinois laws or regulations.

Additional Field Staff

Upon recommendation of the Board's Planning and Priority Committee, up to 3 additional field staff members will be employed in 1973. This recommendation came in conjunction with a study of Resolution 72M-31. The resolution, passed by the 1972 House of Delegates, calls for a study of redistricting of the State Medical Society in accordance with the official State Districts utilized for Health Care Planning and other State services. The additional field staff personnel will be utilized in support of county medical society programs and the work of the ISMS trustees. The number of new personnel to be employed and their location is subject to further discussions with the Finance Committee and budgeting for 1973. In related action, the Board appointed an ad hoc committee to conduct the studies on future redistricting of the Society as required by Resolution 72M-31. The Committee is obligated to report its findings to the House of Delegates in March of 1973.

OLE!

Washington Roundup Goes South

ISMS members and their wives are invited to join the Public Affairs Committee in its annual trip to the Nation's Capital for the Washington Roundup, March 4-11, 1973.

This year's "Roundup" will have a new look. The Washington program has been combined with a brief vacation in San Juan, Puerto Rico.

Included in the Washington program will be: an AMA staff briefing on national health-care legislation; personal visits with your Congressmen and other federal officials and a Congressional Reception.

Interesting medical seminars are being prepared in conjunction with the Puerto Rico Medical Association for your stay in San Juan.

The Washington-San Juan Roundup is $376 per person plus $40 tax and service, including round trip charter flights, the finest first class hotels, and many other exclusive features. THIS IS A FIRST CLASS TRAVEL PACKAGE.

The charter flight will originate and return to Chicago and will include first class meals and service, and complimentary cocktails.

To make your reservation, please fill out and return the coupon below.

Mail to:
Illinois State Medical Society
360 N. Michigan Avenue
Chicago, Illinois 60601

for further information
contact:
Mrs. Betty Duffy
(312) 782-1654

Gentlemen:
Enclosed please find $_____ to apply as deposit for _____ persons.
(Please list every name in the party.)

☐ Check here for single accommodations ($90 extra)
$100 MINIMUM DEPOSIT PER PERSON
Complete balance due by February 1, 1973
Make checks payable to:
Illinois State Medical Society

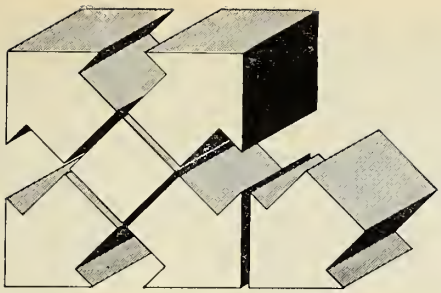
NAME: _____

ADDRESS: _____

_____ ZIP: _____

PHONE: (AC) _____

I live in Congressional District #_____



trauma center

David R. Boyd, M.D.C.M., *Editor*

The Injured Posterior Urethra

By Samuel S. Clark, M.D.C.M./Chicago

Since 1900, many reports in the literature have confirmed that in all pelvic fractures, the incidence of urinary tract injury is about 15% and of these 67.7% involve the posterior (prostatic) urethra.[1] Diagnosis and management has changed very little in this 70-year span and is presented in any standard textbook of surgery. The majority of authors dealing with this subject express their desire for an attempt at primary repair of the urethra while at the same time agreeing that the majority of cases will fail and result in a stricture with long-term morbidity of varying degree. This paradox has prompted us, as well as others, to try to find an alternative treatment regime which in many cases may be a reasonable substitute for the classical but unsatisfactory approach to this problem.

Anatomy

The posterior urethra consists of two segments: a 3.5 cm segment traversing the prostate from bladder neck to verumontanum (the prostatic urethra), and a 1.0 cm segment spanning the gap from verumontanum to the membranous urethra (the supramembranous urethra). The prostatic urethra is relatively immobile as the prostate gland is fixed to the symphysis pubis via the puboprostatic ligaments and the membranous urethra is fixed within the pelvic diaphragm thus allowing minimal mobility of the supramembranous portion.

Samuel S. Clark, M.D.C.M., a graduate of McGill University, Montreal, Canada, is currently Associate Professor in Urology and Head of the Division of Urology, Department of Surgery, The Abraham Lincoln School of Medicine. He is also Chief of Urology at the University of Illinois and Veterans Administration West Side Hospitals in Chicago.



Pathophysiology

The supramembranous urethral segment is the commonest site of posterior urethral injury which results from disruption of the puboprostatic ligaments, thus permitting prostatic mobility with partial or complete disruption of the posterior urethra. Fracture of the pubic or ischial rami frequently acts as a "switch-blade" resulting in a laceration of this segment. Associated with the urethral injury is disruption of the periprostatic venous plexus causing a pelvic hematoma which may displace the prostate cephalad and posteriorly or obscure the gland by the size of the hematoma.

Injury to the posterior urethra without other urinary tract injuries will result in urinary retention, the mechanism of which is not clear, but may well be the loss of leverage needed to initiate the opening of the bladder neck. Thus, while this type of injury leads to large pelvic hematoma, it is not contaminated with urine in contradistinction to anterior vesical ruptures where the hematoma is contaminated with urine.

Diagnosis

Diagnosis of posterior urethral injury before any instrumentation is of paramount importance to prevent complications and to plan a manage-

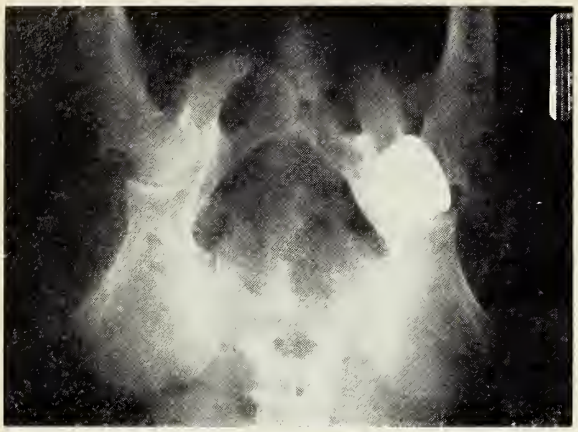


Figure. 1. Plain film of fracture of pelvis prior to surgery.

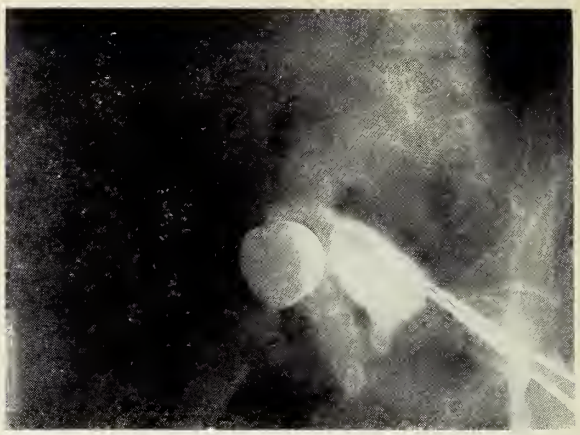


Figure 2. Voiding cystourethrogram after urethroplasty.

ment program.

The type of injury, i.e., pubic arch fractures, the presence of blood at the urethral meatus, the inability to void, the presence of an oval regular suprapubic midline mass, and the loss of prostatic contour on rectal examination should lead the emergency room physician to suspect posterior urethral injury. Once suspected, the patient should have, if his general condition is stable, an infusion I.V.P. to establish the presence or absence of two functioning renal units. Then, in the conscious patient with a full bladder who cannot void, a simple retrograde urethrogram is performed by injecting 15 cc of an organic iodide through the meatus to determine the status of the urethra. If the "dye" passes freely into the bladder without extravasation, urethral cateterization may safely be performed; however, if "dye" is seen to be extravasating, a diagnosis of urethral rupture is established and the passage of a catheter may only lead to contamination of the pelvic hematoma, or worse, may lead to the complete rupture of a partial tear.

Treatment

In treatment of patients with multiple injuries, the posterior urethra takes a low priority, but must not be neglected if a satisfactory outcome is to be anticipated.

The emergency associated with the ruptured posterior urethra is to establish the free flow of urine; the long-term aim is to reconstruct the urethra with little or no morbidity.

Once a ruptured posterior urethra is established, the emergency can be handled simply by the insertion of a suprapubic catheter. The previously mentioned paradox of attempting a primary anastomosis of the urethra at the expense of long-term stricture morbidity does not meet our second principle of management. The contamination of the pelvic hematoma, attendant with any of the procedures designed for primary repair, results in severe pelvic fibrosis which will compromise future attempts at reconstructive surgery. Our aim, then, is to maintain a sterile field free of fibrosis which will permit future surgical reconstruction, if necessary. Therefore, we do not interfere with the pelvic hematoma by digital or instrumental exploration, or by drainage when the hematoma has not been contaminated by urethral catheter or by urinary extravasation. We simply allow the hematoma to be absorbed which results in an afibrotic pelvic field.

The partially ruptured urethra with 50% of its wall in continuity will act as a buried epithelial strip as in the Denis Brown urethroplasty, thus forming an epithelial tube in 10 days, with complete reconstruction of the urethra. If, on the other hand, the urethra has been completely disrupted and the prostate displaced, after reabsorbtion of the hematoma the prostate will return to a relatively normal position. A short fistula will form from supramembranous urethra to membranous urethra amenable to some kind of plastic procedure, such as the Johansson posterior urethroplasty.[2]

In summary, we suggest that partial or complete rupture of the posterior urethra must be diagnosed with a retrograde urethrogram and not with a urethral catheter. In addition, the emergency evacuation of urine should be handled with a high suprapubic cystostomy allowing the uncontaminated pelvic hematoma to

be reabsorbed and resulting in an afibrotic field amenable to future reconstructive surgery. ◄

References

1. Clark, S. S. and Prudencio, R. F.: Lower Urinary Tract Injuries Associated with Pelvic Fractures. *Surg. Clin. No. Amer.*, 52:183-201, Feb., 1972.
2. Johansson, B.: Reconstruction of the Male Urethra in Strictures. *Acta Chir. Scand.*, 105 (Suppl.):176, 1953.

Investment Corner

(Continued from page 580)

Tax Shelters

Another area of year-end tax planning is that of "tax shelter" investments. This type of investment frequently takes the form of an unincorporated business enterprise, since the basic tax planning concepts involved generally rely on the retention of the character of the items of income and deduction in the hands of the investors, and the current deductibility of any losses by the investors against other taxable income. The use of non-cash expenses (such as depreciation and depletion) to create tax deductions, and cash basis accounting, which enables the investor to deduct many expenses long before any income is realized, are the important principles on which the tax shelter feature of these investments operate.

An important thing to remember is that no investment should be made only for the purpose of reducing or deferring income taxes. Also, all tax shelter investments are not appropriate for all individuals, e.g.; an investment may have tax losses for a period of years beyond the investor's high income years; have poor liquidity; and have a high risk factor, etc.

Some of the investments that fall into the category of tax shelter investments are:

- Real estate
- Net leases on personal property
- Oil and gas
- Cattle feeding
- Tax-exempt securities

One further area of year-end tax planning involves gift taxes. Certain amounts can now be given to others on an annual basis free from Federal gift taxes. There is presently some concern that the gift tax rules will be changed in the near future, perhaps for years beginning after 1972.

Action on year-end tax planning is up to each individual and he should consult his tax advisor for specific steps to take which will be of tax benefit. Many times tax planning is put off too long or never taken. This could be costly. ◄

Common Bleeding Disorders

(Continued from page 568)

shunt) and following prostatectomy when no evidence of DIC can be uncovered has been successful. Simultaneous heparin has been administered as a protective measure, although in some of these cases, certain authorities question whether EACA should ever be administered. [81,82] The final status of therapy for this complex area of the formation and dissolution of the fibrin network certainly has not been achieved; however, attention to the underlying cause, together with selective additional measures (heparin, blood components, etc.) should result in the reduction of morbidity and mortality from these disorders.

A strange collection of substances, including carbazochrome salicylate, vitamins, steroids, antihistamines, estrogens, and other compounds have been used for a variety of bleeding problems in the past. Parenteral Vitamin K is too often the first step taken when excessive bleeding begins during surgery, in spite of the fact that it has been well established that this compound is not effective for 4-48 hours following administration. We have been unable to uncover any scientific data to support the use of any of these agents for the control of the acutely bleeding patient.[84]

Summary

Hemostasis may be divided into the processes of vasoconstriction, formation of the primary hemostatic plug, the intrinsic and extrinsic generation of thrombin, and formation of the fibrin network. Screening procedures which we have found most helpful in acutely bleeding patients include the bleeding time, platelet count and morphology, prothrombin time, partial thromboplastin time, thrombin time, fibrinogen level, and split products assay. The application of these principles, including the use of specific component therapy, will result in more effective control of clinical problems associated with acute hemorrhage. ◄

References

A complete bibliography for "Common Bleeding Disorders" is available upon request to the *Illinois Medical Journal*, 360 N. Michigan Ave., Chicago, 60601; (312) 782-1654.

what goes on

a guide to continuing education

January 12-13—University of Texas Graduate School of Biomedical Sciences

Symposium on the Application of Nutrition in the Health Sciences

The goal of this symposium is to bring together scientists and clinical investigators in the field of nutrition for the purpose of sharing their work and enthusiasm with the physicians and health scientists of this region.
There will be an evening meeting open to interested groups at which Dr. Arnold E. Schaefer will speak on "Human Malnutrition and Neurological and Mental Development."
Registration Fee: $25.00
Contact: The Office of the Dean, The University of Texas Graduate School of Biomedical Sciences at Houston, Division of Continuing Education, P.O. Box 20367, Houston, Texas 77025.

University of Texas, Houston, Tex.

January 19—The Chicago Gynecological Society

Scientific Program

This will be a Holmes Lecture and will be delivered by Dr. Robert E. Scully of Harvard Medical School.
Contact: Mario D. Oriatti, M.D. (312) 887-2200.

Drake Hotel, Chicago

January 19-20—Arizona Heart Association

16th Annual Cardiac Symposium

An outstanding panel of speakers has been assembled to assure a program of interest to scientists and practitioners concerned with "what's new" in cardiovascular medicine.
The program has been approved for post-graduate credit under Category One by the American Academy of Family Physicians.
Contact: Arizona Heart Association, 1720 E. McDowell Road Phoenix, AZ 85006

Mountain Shadows Resort Hotel, Arizona

January 5-22—Albany Medical College

Post-graduate Medical Seminar Cruise

An 11 day cruise from New York aboard the luxurious and distinguished ship "Gripsholm" of the Swedish American Line. Port of call include St. Maarten, Martinique, Barbados, St. Vincent, Grenada, Curacao, Antigua and St. Croix.
Contact: Frank M. Woolsey, Jr., M.D., Department of Post-graduate Medicine, Albany Medical College, Albany, New York 12208

January 24—Martha Washington Hospital

"Oral Surgery" Lecture

The lecture will be on Wednesday, at 9:00 a.m.-10:00 a.m. It will be given by Mittleman, D.D.S.
Contact: Fernando Lopez-Fernandez, M.D., Medical Director, Martha Washington Hospital, 4055 N. Western Avenue, Chicago, Illinois 60618

January 24-26—Northwestern University Medical Center

Postgraduate course—The Year in Internal Medicine

The guest faculty will include Dr. Henry Blackburn, University of Minnesota; Dr. Allan J. Erslev, Jefferson Medical College of Thomas Jefferson University; Dr. T. R. Johns, University of Virginia School of Medicine; Dr. Stanley G. Korenman, University of Iowa; Dr. David H. Law, University of New Mexico School of Medicine; Dr. Michael Levitt, University of Minnesota; Dr. Donald E. Oken, Harvard Medical School; Dr. Alfred Pick, Michael Reese Hospital; Dr. Kenneth Rosen, University of Illinois College of Medicine; Dr. Sydney E. Salmon, The University of Arizona; Dr. Leslie J. Schoenfield, U.C.L.A., Cedar-Sinai Medical Center; Dr. Louis Sherwood, Michael Reese Hospital.
Contact: Northwestern Memorial Hospital, Passavant Pavillion, 303 E. Superior St., Chicago, IL 60611

Offield Auditorium, Chicago (Passavant Pavillion)

February 7-9—Nuclear Medicine Department, University of Michigan

Western Michigan Nuclear Medicine Conference

This conference will be jointly sponsored by the Hackley Hospital, Medical Assist., and the Central Chapter of the Society of Nuclear Medicine.
This is offered for General Practitioner, Surgeons, Internists, Pediatricians, Physicians and Technologists, Practicing in the field of Nuclear Medicine.
Contact: James C. Carlson, Nuclear Medicine Department, Hackley Hospital, Muskegan, Michigan

Holiday Inn, Petosky, Mich.

membership forum

Reply on Insurance Rates

Editor's Note: The following is a response letter sent from the Legal Research Department of the American Medical Association to an Illinois physician who was concerned about malpractice insurance rates.

October 5, 1972

Dear Doctor:

I understand and sympathize with your concern about the rising cost of malpractice insurance.

I understand that you have your coverage under the program sponsored by the Illinois State Medical Society. The AMA is *not* a co-sponsor of that program which was in existence long before an AMA program was developed. I do not intend to imply, however, that sponsorship by AMA would have kept the costs down. I am sure that ISMS did everything they could to keep costs down.

Insurance premium rates are based on estimates of what future expenses will be on the basis of past experience. As damage awards and settlements and legal expenses continue to increase, insurance companies have to increase their premiums to maintain adequate reserves for future losses. Otherwise the company might go bankrupt which would leave the physician without any protection.

Since you have had no malpractice claims, I can understand your irritation about paying insurance to cover those who have had claims. This, however, is exactly what insurance is all about.

Each of us buys fire insurance on his house, not because he expects it to burn down, but because he knows it could happen. Most home owners never have a fire, even though they pay insurance premiums for many years. If one could be sure, in advance, that he would not have a fire he could save a lot of money by not carrying insurance. Few of us, however, would want to take that risk.

The same ideas apply to malpractice insurance. If claims were made only against physicians who are incompetent, unscrupulous and unethical, it would be relatively easy to keep insurance costs down by excluding them from coverage. The fact is, however, that even the best qualified, most competent, and most ethical physicians have claims made against them.

No physician can be sure that none of his patients will suffer an untoward complication of treatment. Any such complication could result in a claim. Even if a claim is not successful, it results in large costs for defense. On the other hand, a claim that results in an award does not necessarily mean that the physician is incompetent. At most it means that in one particular instance he slipped from the high standard of skill and care required by law and caused an injury to a patient. Everyone, being human, slips occasionally. Most slips do not cause serious injury to a patient but some do and these may result in damage awards.

The real reason why malpractice insurance costs have been skyrocketing is not that physicians are causing more injuries than ever before or that physicians are more careless than ever before. The real reason is that physician's patients and their families are becoming more and more willing and ready to sue the physician for any real or imagined injury.

Your reaction of thinking about withdrawing from membership is a natural one. I hope, however, that you will reconsider. Even though you may not be satisfied with what they have accomplished, your medical organizations are the only ones which are trying to protect your interests. A sponsoring medical society can make an insurance carrier prove that increased premiums are needed to cover losses. A physician who buys his insurance individually has no way to make the insurance company do anything.

I am not going to try to defend insurance companies. They make a lot of money, especially on life insurance. They also make money on investment of policyholders' premiums. I do not think that many of them have made profits on malpractice insurance, at least in recent years. In any event, physicians cannot get along without insurance. They have to get along with insurance companies the best they can until something better comes along.

Yours very truly,
Legal Research Department
American Medical Association

MEDIPHONE Service Available

Dear Editor:

MEDIPHONE, a Nationwide Physicians' Consultation System, has been established by the American Society of Contemporary Medicine and Surgery, under the leadership of Dr. Michael DeBakey, President, and Dr. Morris Fishbein, Chairman. The Society will provide medical information and consultation to physicians by telephone. Now any physician, regardless of his geographic location, can call (312) 782-7888 and receive expert advice from one of 400 outstanding specialists in all fields of medicine and surgery. This service is available to all physicians and does not require membership or pre-registration. It is hoped that physicians will use this valuable service when faced with perplexing medical problems. The charge for a five minute conference with a prominent specialist is $15.00.

John G. Bellows, M.D., Ph.D.

Measles High Cause of Death

October 18, 1972

Dear Editor:

An alarming increase in reported morbidity due to measles in Illinois indicates a severe problem. The following figures show the problem and the urgent need to implement methods to combat it.

MEASLES

Year	Cases		Deaths	
	Entire State (incl. Chgo.)	City of Chicago	Entire State (incl. Chgo.)	City of Chicago
1966	11,514	3,331	27	10
1967	1,347	630	3	2
1968	1,291	986	2	2
1969	1,746	1,411	4	3
1970	3,085	1,659	12	11
1971	3,460	422	4	0
1972	4,104	1,030	0	0

(1972—measles cases reported 1/1/72-9/30/72
measles deaths reported 1/1/72-4/30/72)

On the basis of past experience, we suspect that the actual number of cases of measles occurring in Illinois may be as many as ten times the number reported.

The critical factor underlying the spread of measles in recent outbreaks is susceptible school children. Every large epidemic we have investigated during the past year has been school-based in origin. The difficulties in aborting these epidemics have been numerous; however, our experiences have demonstrated the importance of a rapid remedial immunization program when an outbreak begins.

For immediate emergency action to combat the measles problem in Illinois during the coming winter and spring, the following is planned:

1) Assignment, within 24 hours, of a special "fire-fighting" team to any county in the State if five or more cases of measles are reported and found related.
2) The team will contact the attending physicians to verify the diagnosis and locate the cases geographically, and to discuss the actions necessary to abort an epidemic before the next generation of disease occurs.
3) If a measles problem is evident, appraisal of representatives of the local medical society of the problem and solicitation of their sponsorship and participation in an immediate emergency local measles vaccination program.
4) Rapidly (if possible, within 4 to 5 days of notification of cases to the Illinois Department of Public Health) conduct a localized vaccination program with school (if involved), medical society and Illinois Department of Public Health support; or utilizing contract physician services if the medical society is unable to provide sponsorship and participation within the necessary time limits.

On the basis of past years' experience and reports, we expect that this approach will minimize the effect of depressed immunization levels in some localities.

Yours sincerely,
Franklin D. Yoder, M.D.
Director of Public Health

Announcement from the Rheumatic Fever Registry

Dear Editor:

The Chicago Board of Health started a new program in July, 1972, in which registered patients with rheumatic heart disease (and already on rheumatic fever prophylaxis) will be provided with erythromycin upon request for use prior to dental procedures, for the prevention of Subacute Bacterial Endocarditis.

Rheumatic Fever Registry has prophylactic medication available to registered patients, who are undergoing dental or surgical procedures and for whom it may be financial hardship.

Physicians and dentists may obtain special S.B.E. cards from the **Rheumatic Fever Registry—Tel: 744-4275**—and after filling in the information requested in regard to procedure, medication, etc., the card is given or mailed to the patient who then takes the card to one of the pharmacies participating in the Program where the medication is dispensed. The pharmacist mails back the card to the Rheumatic Fever Registry.

For most patients with Rheumatic Heart Disease on continual prophylaxis for Rheumatic Fever (Oral Penicillin, Sulfa or Benzethine Penicillin G) the following schedule is recommended in all dental and orthodontic procedures that are likely to cause bleeding.

Erythromycin — **Oral**

Adults: 500 mgs 1½ to 2 hours prior to procedure and then 250 mgs every 6 hours for the remainder of that day and for the 2 days following procedure.*

Children: The dose for small children is 20 mgs/Kg orally 1½ to 2 hours prior to procedure and then 10 mgs/Kg every 6 hours for day of the procedure and next 2 days.

Sincerely yours,
Sophie Levinson, M.D., FAAP
Rheumatic Fever Medical Officer
Rheumatic Fever Control Program
Chicago Board of Health
Division of Adult Health and Aging

*Or longer in the case of delayed healing.

Licensure and Credentialing of Health Manpower

(Continued from page 572)

things which only he can do. Aides and assistants will take medical histories, do many parts of physical examinations, carry out numerous tests. Other types of assistants and surrogates will render well baby care, normal pre-natal care and supervise treatment of stable conditions. They will identify and separate the healthy from the sick and take care of a good share of the former.

In rural health system satellites, similar types of people will do similar things with their connections to the physician by telephone, television and telemetry of vital functions.

We cannot inhibit these types of development by licensure. There is no way of licensing such individuals without limiting the very purpose for which they were created.

The HMO should be licensed and in the process satisfy the examiner concerning its intended functions, how it plans to carry them out, the standards it has set for itself and the method of measuring performance.

By analogy the same process should function in the physician's office. Let's not license his assistant. Let us make sure the doctor's license and the Medical Practice Act permits him to delegate appropriate tasks to an assistant or assistants without subjecting himself to increased liability. This does not absolve him of ultimate responsibility, but gives him license as to how to exercise that responsibility.

If he believes that a proper examination of a seemingly normal person can be carried out in accord with his standard by an assistant, then he should search out and use an assistant with that degree of competency. He may find that any one of a number of different training or educational processes will produce this competency; or he may wish to train his office nurse or his housewife clerk. The issue is demonstrated competency for the needed task.

The justification or defense of his actions will reside here again in a quality assessment program.

What about other types of credentialing? In the system I advocate the state has an increasing responsibility for certification of the educational processes. The hospital, the HMO, the physician will characterize functions, will create job descriptions based on task analysis and as part of that process list minimal qualifications. Many of the potential candidates for these positions will be products of vocational, junior and senior colleges and professional schools. There must be reasonable assurances that their learning experience does qualify them as advertized and that the descriptors of their capabilities are accurate. In other words, that the diploma or certificate or document has meaning.

The state's certification responsibility for the educational institution is somewhat analogous to their licensing responsibility for the hospital. It is the expression of the state's responsibility for the overall process, and the meaningful product, not the details of each step along the way. The credentialing responsibility must follow these lines if it is to facilitate progress without jeopardizing quality.

Summary

1) We now have a very conventional health care system which is basically private practice and fee-for-service oriented. 2) We have the conventional problems including the fact that many cannot gain access to the system for two fundamental reasons: (a) irregular distribution of physicians, and (b) increasing financial barriers as costs increase.

These problems will soon accelerate as universal health insurance increases demand if the system cannot increase its productivity. 3) Productivity and availability will increase only by introduction of alternative methods which in themselves will be attractive, but which will also stimulate the existing system to become more efficient. 4) These developing alternatives will require the use of existing types of health professionals in modified roles and new types of personnel to assume delegated responsibilities. 5) Within organized systems of care extension of licensure to cover these individual situations will be inhibitory and not in the public interest; 6) Licensure should be limited to individuals, institutions and systems which function autonomously, thereby assuming ultimate responsibility. In this circumstance licensure need be renewable and based on evidence of continuing competency. 7) The function of all others than licensees should be mandated via the delegatory powers of the licensees. 8) The justification of the process must be by means of continuous assessment of quality of care. 9) The state must continue and strengthen its responsibility for certification of the educational processes which will be involved in the production of many of these people resources. ◄



Morton C. Creditor, M.D., is Executive Director, Illinois Regional Medical Program.



practice management

The Care and Feeding of a Collection Agency

By Kurt Bennett, Consultant of Professional Business Management, Inc., The 400 Center, 400 County Line Road, Deerfield, 60015

A collection agency doesn't exactly enhance your reputation in the community, but a poor agency can hurt you. The very idea of a collection agency repulses most people; yet fairness to your patients that do pay promptly and fairness to yourself may force you to use an agency. If you must use one, get the most from it.

Choosing Your Agency

You need an agency with financial stability, a favorable reputation for ethical collection practices and one that gets results. Check with your colleagues and professional business consultant for recommended agencies. A very few agencies have histories of credit problems of their own. However few they may be, you don't want such a one; contact the agency's bank reference. Call your Better Business Bureau to see if complaints have been lodged about such practices as telephone calls in the middle of the night.

Results? Don't expect miracles! Larger agencies usually concentrate on volume for their profits and may average a 20% collection ratio on all types of collections. Smaller agencies may range up to a 35% collection ratio. Consequently, for every $1,000 in collection accounts you give your agency, you may net only an average of $100 to $200, after the agency deducts its fee, depending on what that fee is.

Generally the best agency to use is one affiliated with the local credit bureau because that agency will have your collection placed on the patient's credit record. Often a person must clear up collections before getting new credit. Usually, collections placed with other agencies do not get recorded on the patient's credit report. In choosing between a large or a small agency, the smaller one is usually a better choice, since the owner is more likely to know you and want you as a client.

Get An Agreement

Your agreement on fees should be simple. The agency will probably quote fees from 25% to 50% on different categories of accounts. Nearly all of the accounts you send will be in the highest fee bracket due to their age. For simplicity and because the agency's clerks often have the annoying habit of charging you the highest fee regardless, negotiate one flat fee to cover all of your regular collection accounts and one higher rate for legal accounts. Try for a

(Continued on page 609)

View Box

(Continued from page 582)

DIAGNOSIS: *Rheumatoid Arthritis*—The significant roentgen changes in the cervical spine

1. Narrowing multiple discs including upper two
2. Little osteophytosis and sclerosis
3. Erosion vertebral end plates
4. Subluxations of vertebrae
5. Erosions and/or fusion of apophyseal joints
6. Subluxation of atlanto-axial and occasional basilar invagination
7. Erosion of spinous processes

The interesting changes seen in this condition occur around the C_1, C_2 level where there is a relaxation of the transverse ligaments which maintain the odontoid process in proper alignment with the inner aspect of the anterior portion of ring of C_1. When these ligaments are loosened up due to involvement by rheumatoid disease there is also a considerable amount of resorption of the odontoid itself so that it becomes almost paper thin (Figure 2). At that point there may be a forward slipping of C_1 on C_2 with atlanto-axial subluxation. These cases have occasionally been accompanied by cervical cord compression and possible quadriplegia.

The maximum permissible distance from the anterior aspect of the odontoid to the posterior aspect of the ring of C_1 should be no more than 3.5 mm. in a flexion position. The spinous process of C_7 is a typical finding in rheumatoid arthritis and has been likened to the appearance of a bayonet. ◄

Prolonged Pregnancy

(Continued from page 563)

managed. In cases where the mother is carrying a large infant cephalopelvic disproportion must be ruled out both by clinical estimation of the size of the pelvis and by X-ray pelvimetry. Long, difficult labors should be avoided.

Prolonged pregnancy is a problem of declining placental function. With increasing ability to measure placental performance and the application of these technics to unveil fetal jeopardy, the problems of the pregnancy that goes beyond term can be managed in a logical fashion. Certainly, to induce labor in all patients who have reached 42 weeks gestation is to invite an increased mortality from management alone. The degree of fetal metabolic reserve should be ascertained and the method of delivery planned accordingly. (Fig. 5) ◄

References

A complete bibliography for "Prolonged Pregnancy: A Problem of Declining Placental Function" may be obtained from the *Illinois Medical Journal*, 360 N. Michigan Ave., Chicago, 60601; (312) 782-1654.



Prescribe
the discoverer's brand
Totacillin®*
(ampicillin trihydrate)

*capsules equivalent to 250 mg. and 500 mg. ampicillin, for oral suspension equivalent to 125 mg./5 cc. and 250 mg./5 cc. ampicillin.

BMP
Beecham-Massengill Pharmaceuticals
Division of Beecham Inc. Bristol, Tennessee 37620

Obituaries

*Christie, Charles W., Champaign, died September 23, at the age of 73. He completed his premedical studies at the University of Illinois, and was granted a medical degree from Northwestern University in 1922.

Churchill, Edward D., died August 28, at the age of 77. He graduated from Northwestern University and received his degree of doctor of medicine at Harvard University in 1920. For his services during the war he was awarded the European Theater Service Medal with four battle stars.

*Crain, Carter, Menio Park, died October 22. He had retired 3 years ago after 45 years as a physician in Chicago. He was also a graduate of Northwestern University Medical School and formerly taught there.

*Dorris, Victor M., died September 7, at the age of 57. He was an alumnus of the University of Illinois. His practice was limited to gynecology and obstetrics.

*Groegemueller, E. H., Elmhurst, died November 3.

*Lally, John M., died October 23, at the age of 64. He practiced medicine in Chicago for 35 years. Dr. Lally was a founding member of Ressurection Hospital and a leader in its planning and development.

**Loar, Ralph, died at the age of 81 on October 3. He was elected president of the McLean County Medical Society in 1951. In 1960, he was appointed to the maternal welfare committee of the Illinois State Medical Society and in 1968 became a member of the 50 Year Club.

**Lyon, Will F., died at the age of 83 on November 4. He retired as head of the International Harvester's medical department in 1955 after 13 years of service. He was also an attending member of the surgical staff at Presbyterian St. Luke's Hospital and an assistant professor of the University of Illinois School of Medicine. International Harvester established a $300 annual cash prize in 1955 in Dr. Lyon's name for outstanding interns.

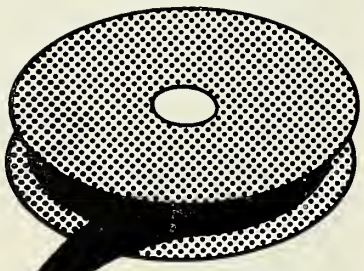
**Murphy, Frank, died October 7, at the age of 83. He had instructed doctors for 50 years in bone surgery while professor of orthopedic surgery at the University of Illinois and Cook County Graduate School of Medicine. Dr. Murphy was also a past president of the Chicago Orthopedic and Clinical Orthopedic Societies.

*Scheman, Louis, died November 4. He took up residents in Highland Park and was a member of the American Academy of Orthopedic Surgeons International College of Surgeons and a fellow of the American College of Surgeons.

*Schnute, William J., of La Grange, died at the age of 58. He was an orthopedic surgeon with offices in Chicago. Dr. Schnute was also on the faculty of Northwestern University School of Medicine.

**Indicates member of ISMS.*

***Indicates member of ISMS* and *Fifty-Year Club.*



Greatest Advance Since the Typewriter was Invented! No More Smeary Erasing—Covers Mistakes Instantly, Permanently!

SELF-CORRECTING TYPEWRITER RIBBON!

Most exciting, needed advance since the typewriter was invented! As of this moment, every messy, smudgy, smeary typewriter eraser in the world hits the scrap heap for good. No more erasing—ever! Bottom half of miracle ribbon is like a magic wand that makes errors disappear before your eyes. To make corrections, just back space, shift ribbon selector and retype error. Presto! White ink makes error completely invisible. Order extra ribbons for friends. This is one gift they'll love you for! No CODs.

MAIL ORDER MART, Dept. 14
2701 Sterlington Road, Suite 132
Monroe, Louisiana 71201

Please send me the quantity of ribbons checked below. If not satisfied, I will return ribbons within 10 days for full refund.

☐ 1 ribbon $3.50 ☐ 2 ribbons $6.00

Brand Name of Typewriter—
☐ Standard ☐ Electric ☐ Portable

Name_____

Address_____

City_____ State_____ Zip_____

(Continued from page 606)

33⅓% to 40% fee for regular accounts and 40 to 50% plus court costs for legal accounts. Court costs are usually nominal and do not include the attorney's fee. Paying him is the agency's problem.

The agency should agree *in writing* that you have the authority to withdraw any account for any reason at any time—even if legal action is pending. It should be agreed that you have the right to cancel the bill or compromise it. Of course, if collections on an account are already being made by the agency, you can't withdraw the account without giving the agency some compensation. The agency should agree not to begin legal action without your prior approval. You should agree to halt all collection activity, even statements, once you assign the account.

Watch What You Send

Don't use the agency as a dumping ground. Small balance accounts and small skip accounts just won't get much collection effort. On the other hand, if your agency is affiliated with the local credit bureau, it's probably a good idea to send all delinquent accounts so they'll be entered on the patient's credit record. Don't expect good results, though, on small skips and small balances.

The key man at your agency is the collector. He gets a commission on what he collects. Why should he waste time on your $5 account when he can work on a $200 account for someone else? And, why should he waste time locating your $25 skip account? Generally, it isn't recommended to assign accounts under $15 or skip accounts under $50 until your own staff has done all it can to locate the patient. Don't send accounts that you know for fact are hopelessly uncollectable. An agency salesman will tell you to send all delinquent accounts, regardless of size or status, because he usually gets a commission on the total dollar amount you assign to the agency.

The agency results depend on that collector and not the salesman who caters the collector. The easier it is for the collector to contact your accounts, the greater his results. Too, he may develop a favorable impression of your business and work your accounts harder than some others. Give him all important information you have as well as every name, previous address, previous employment and phone number. If your ledger cards have all that information, you might send a photocopy.

(Continued on page 610)



Prescribe
the discoverer's brand
Pyopen®*
(disodium carbenicillin)

*vials for injection equivalent to 1 gm. and 5 gm. of carbenicillin.

BMP

Beecham-Massengill Pharmaceuticals
Division of Beecham Inc. Bristol, Tennessee 37620

Practice Management

(Continued from page 609)

Agency Follow-Up

You can tabulate the agency's results by keeping a simple roster. Whenever you assign an account, note only the month and amount. When you get recovery on an agency account, note the month and gross amount collected in a second column. Divide the gross amount recovered by the amount assigned to arrive at the agency's collection ratio.

Semi-annually your aide should make a list of all agency accounts that have not been paid within the preceeding two months nor made any payment at all, leaving enough space between each name for the agency's reply. She should send the list to the agency requesting a report on the collection progress of each account and instructing the agency to return accounts that it feels are uncollectible. February and August are good months for asking for these reports. Your request will jolt renewed activity on some accounts. Those accounts the agency returns will clean up the dead-wood and should then be written off by your office. The agency keeps an index record on all accounts assigned to it, and, if anything promising turns up in the future on an account that it returned to you, the agency will request that you reassign the account.

When you assign an account, your ledger card should be clearly marked and should show the date assigned. If you get a phone call from the patient, get the patient's phone number and tell him you'll have the agency call him. Don't make financial arrangements with the patient unless you have conferred with the agency first. Credit the patient's account with the gross amount the patient paid to the agency or paid directly to you. Also, indicate the agency's fee on the card. Remember, you can not charge the patient for the fee you give to the agency. ◄

Facts From AMA . . .

- There were 112 medical schools in the U.S. in 1972, compared with 86 in 1960.

- There were an estimated 345,000 physicians in the U.S. at the start of 1972. This represents a ratio of one doctor for every 612 Americans, compared with one for every 712 in 1960.

ANOTHER ISMS MEMBERSHIP PRIVILEGE

LOW-COST GROUP INSURANCE

GROUP
DISABILITY PLAN

- NEW—Guaranteed renewable feature
- Sickness benefits to age 65
- Up to $250.00 weekly benefits

(PROTECT YOUR INCOME AND SECURITY)

GROUP
SUPER MAJOR MEDICAL PLAN

- Up to $50.00 daily room and board
- Up to $25,000 for each accident or sickness
- In hospital and out of hospital expenses

(TRULY CATASTROPHIC PROTECTION)

FOR INFORMATION, ASSISTANCE & DETAILS CONTACT:

Administrators:

PARKER, ALESHIRE & COMPANY
ESTABLISHED 1901
Insurance

9933 N. Lawler Avenue
Skokie, Illinois 60076
Phone: 312-679-1000

COOK COUNTY
Graduate School of Medicine

CONTINUING EDUCATION COURSES
STARTING DATES—1973

SPECIALTY REVIEW IN GENERAL SURGERY, PART II, February 5
SPECIALTY REVIEW IN PEDIATRICS, April 2
SPECIALTY REVIEW IN NEUROLOGY, BASIC, April 2
REVIEW IN NEUROPATHOLOGY, One Week, April 9
SPECIALTY REVIEW IN THORACIC SURGERY, April 2
SPECIALTY REVIEW IN DERMATOLOGY, April 30
SPECIALTY REVIEW IN OBSTETRICS & GYNECOLOGY, April 30
MANAGEMENT OF COMPLICATIONS IN SURGERY, Four Days, March 6
PRE & POSTOPERATIVE CARE OF PATIENTS, Four Days, March 13
BLOOD VESSEL SURGERY, One Week, March 26
SURGERY OF GASTROINTESTINAL TRACT, Four Days, April 9
PROCTOSCOPY, SIGMOIDOSCOPY & FIBEROPTIC COLONOSCOPY, Three Days, April 25
BASIC OBSTETRICS, One Week, April 2
BASIC GYNECOLOGY, One Week, April 9
VAGINAL APPROACH TO PELVIC SURGERY, One Week, Jan. 15
BASIC ELECTROCARDIOGRAPHY, One Week, March 5
BASIC INTERNAL MEDICINE, One Week, March 19
STATE & NATIONAL BOARD REVIEW, BASIC, April 29, Clinical May 7
INHALATION & REGIONAL ANESTHESIA, Request Dates

Information concerning numerous other continuation courses available upon request.

Address:

REGISTRAR, 707 South Wood Street,
Chicago, Illinois 60612

E & M MEDICAL LABORATORIES, INC.

Near South Side

2600 S. Michigan Ave., Suite 312

Chicago, Illinois 60616

Complete Laboratory Services

including PAP Smears

Computer Processed EKG's

and V.D. Tests

EARL N. CALDWELL, M.D.,

PATHOLOGIST, DIRECTOR

(312) 842-1302



Prescribe
the discoverer's brand
Bactocill®*
(sodium oxacillin)

*capsules equivalent to 250 mg. and 500 mg. oxacillin and vials for injection equivalent to 500 mg. and 1 gm. oxacillin.

BMP
Beecham-Massengill Pharmaceuticals
Division of Beecham Inc. Bristol, Tennessee 37620

Index to Volume 142

July through December, '72

Page 1-88	July
89-164	August
165-260	September
261-440	October
441-536	November
537-618	December

A

Abatso, George W., Elective interval appendectomy for recurrent right lower quadrant pain 131
ABSTRACTS OF BOARD ACTIONS, Board of Trustees Meetings 26, 182, 544
Air traffic controllers, Peptic ulcer, (Richard Grayson) 111
Allan, David, Society of Critical care medicine 128
American Association of Medical Assistants-Illinois Society 150, 230, 360
American Medical Association Delegates (**REFERENCE ISSUE**) 325
Ancillary Organization (**REFERENCE ISSUE**) 358
A new health professional; the trauma coordinator, (Kenneth Mains, David R. Boyd, and Bruce Flashner) 158
Ano-rectal crisis, (Crile Doscher) 54
Anstett, James, Unemployment compensation and the solo doctors (**PRACTICE MANAGEMENT**) 62
Are medical unions inevitable?, T. R. Van Dellen (**EDITORIAL**) 433
Aspects of nutritional status of pre-school children in the United States 1968-70 (George Owen) 156
Auxiliary, Woman's (**PULSE**) 69, 154, 222, 586
(**REFERENCE ISSUE**) 507

B

Be your own tax collector (Richard B. Currie) (**PRACTICEMENT MANAGEMENT**) 508
Beal, John M., editor (**SURGICAL GRAND ROUNDS**) 37, 121 494
Bennett, Kurt, The care and feeding of a collection agency (**PRACTICE MANAGEMENT**) 606
Blood pressure, The relationship of degenerative disease to (S. K. Robinson) 116
Board of Trustees (**ABSTRACTS OF BOARD ACTIONS**) 26, 182, 544
Bornemeier, W. C. (**EDITORIAL**) What should a teaching case teach? 85
Boyd, David R. (**TRAUMA CENTER**) jt. author, A new health professional, the trauma coordinator 158
A preview: a total emergency medical system for Illinois 486
Brown, Murry C., (**EDITORIAL**), The private physician's role in VD control 470
Burd, Laurence, jt. author, Prolonged pregnancy a problem of declining placental function (Scommegna) 559
Byerhof, Lloyd A., Year-End tax planning (**INVESTMENT CORNER**) 580

C

Caprini, Joseph, jt. author, Diagnosis and treatment of common bleeding disorders, (Kurtides) 564
Care and feeding of a collection agency (Kurt Bennett) (**PRACTICE MANAGEMENT**) 606
Clark, Samuel S., The injured posterior urethra (**TRAUMA CENTER**) 599
Cleveland, Joseph C., jt. author, Kinked internal carotid artery; observation on etiology (McCormack) 56
CLINICS for crippled children 58, 119, 227, 422, 509, 585
Committees of the ISMS Board of Trustees (**REFERENCE ISSUE**) 343
Common bleeding disorders, treatment and diagnosis of, (Caprini and Kurtides) 564
Constitution and bylaws of ISMS (**REFERENCE ISSUE**) 304
Cooper quiz (Department of Medical Education) 136
Creditor, Morton C., Licensure and credentialing of health manpower, 569
Currie, Richard B., Be your own tax collector (**PRACTICE MANAGEMENT**) 508

D

DeHaen, Paul (**NEW PHARMACEUTICAL SPECIALTIES**) 59, 102, 234, 420, 510
Depression, drugs in the treatment of, (Gerald L. Klerman) 44
Diamond, Eugene, and Rosemary, jt. author, Hot Line crisis counseling service for pregnant women 220
Diener, Allen, (**PRACTICE MANAGEMENT**) Tax shelter 430
DOCTORS LIBRARY 65
DOCTORS NEWS 143, 239, 423, 515, 593
Dogot, Elizabeth, jt. author, Trends in gonorrhea ecology (Modrijan and Leonida) 199
Doscher, Crile, Ano-rectal crisis 54
Drugs in the treatment of depression, (Gerald Klerman) 44

E

EDITORIALS:
Thieving in libraries, (T. R. Van Dellen, M.D.) 63
What should a teaching case teach, (W. C. Bornemeier) 85
Schools without walls, (T. R. Van Dellen) 129
"Right" to medical care, (T. R. Van Dellen) 198
Are medical schools inevitable (T. R. Van Dellen) 433
The private physician's role in VD control (Murry C. Brown) 470
EKG OF THE MONTH, (John R. Tobin, Rimgaudas Nemickas, Patrick Scanlon, John F. Moran, and James V. Talano) 49, 135, 215, 432, 472, 583
Elective interval appendectomy for recurrent right lower quadrant pain, (George W. Abatso) 131

F

FDA overview of nutritional guidelines and nutritional labeling, (Robert M. Schaffner) 205
Flashner, Bruce A., (**TRAUMA CENTER**) jt. author, A new health professional, the trauma coordinator 158
Fletcher, James L., (**REFERENCE ISSUE**) Medical legal information 405
Forkosh, David S., (**TRAUMA CENTER**) a Plan for organization of emergency services on Chicago's north side 209
Free standing committees (**REFERENCE ISSUE**) 345
Friedell, Morris T., jt. author, The value of the screening program on the incidence of sickle cell disease. (Albert Sion) 124

G

Gelperin, Abraham, Recurdescence of preventable communicable diseases 218
Gorback, Sherwood L., (**TRAUMA CENTER**) jt. author, Infections following abdominal trauma 50
Government, Illinois State (**REFERENCE ISSUE**) 369
Grayson, Richard, Peptic ulcer in air traffic controllers 111

H

Hartman, Robert, (**MATERNAL DEATH STUDY**) No. 5, 42; No. 6, 120; No. 7, 213; No. 8, 489; No. 9, 584
Haughton, James G., (**MEMBERSHIP FORUM**) Over specialization injuries health care coverage 48
Higgins, Jack, (**INVESTMENT CORNER**) 61, 216
Hospitals of special types (**REFERENCE ISSUE**) 390
Hot line crisis counseling service for pregnant women, (Eugene Diamond and Rosemary Diamond) 220
House amends bylaws (**Special article**) 66
House of delegates, ISMS (**REFERENCE ISSUE**) 326

I

Illinois Foundation for Medical Care (**REFERENCE ISSUE**) 361
Illinois Political Action Committee (IMPAC)—(**REFERENCE ISSUE**) 360
Illinois Society, American Association of Medical Assistants 150, 230, 360
Illinois State Government (**REFERENCE ISSUE**) 369
Department of Children and Family Services 370
Department of Mental Health 371
Department of Public Aid 371
Department of Public Health 375
Department of Registration and Education 380
Index to (**REFERENCE ISSUE**) 412
ISMS (Constitution and Bylaws) 304
Industry's response to nutritional challenges (R. E. Smith) 573
Infections following abdominal trauma (**TRAUMA CENTER**) (Nichols, Thadepalli and Gorbach) 50
Injured posterior urethra, The (Samuel S. Clark) (**TRAUMA**) 599
INVESTMENT CORNER
Too many doctors take the wrong Rx 61
The split in real estate concept 216
The 50% maximum tax on earned income 506
Year-End tax planning 580

ISMS organization (**REFERENCE ISSUE**) 300
Charts (House of Delegates) 335
(Staff Organization) 349
ISMS recommendations on health care licensure 497
ISMS services (**REFERENCE ISSUE**) 348

J

Jirka, Frank J., Jr., (**PRESIDENTS PAGE**) 8, 96, 171, 276, 452, 554

K

Kinked internal carotid artery; observation on etiology, (Cleveland and McCormack) 56
Klerman, Gerald L., Drugs in the treatment of depression 44
Kurtides, E. S., jt. author, Diagnosis and treatment of common bleeding disorders, (Caprini) 564

L

Lambrecht, J. Douglas, jt. author, Sarcoma Botryoides of the cervix (O'Leary) 33
Lanuza, Vincent L., The 50% maximum tax on earned income (**INVESTMENT CORNER**) 506
Legislative report (**Special article**) 245
Leonida, Domingo, jt. author, Trends in gonorrhea ecology (Modrijan, and Dogot) 199
Licensure and credentialing of health manpower (Morton C. Creditor) 569
Love, Leon, (**VIEWBOX**) 43, 130, 204, 431, 509, 582

M

Mains, Kenneth, D., (**TRAUMA CENTER**) jt. author, A new health professional: the trauma coordinator 158
Many, Seth, E., (**MEMBERSHIP FORUM**) Are midwives practicing medicine? 48
MATERNAL DEATH STUDY 42, 120, 213, 489, 584
McCormack, William M. jt. author, Kinked internal carotid artery; observation on etiology (Cleveland) 56
Medical and paramedical education (**REFERENCE ISSUE**) 362
Medical aspects of college football (Stephen E. Reid) 191
Medical legal information (**REFERENCE ISSUE**) (James L. Fletcher) 405
MEMBERSHIP FORUM
Overspecialization injuries health care coverage (James G. Haughton) 48
Are midwives practicing medicine? (Seth E. Many) 48
IDPA (Robert Wessel) 518
Reply on insurance rates (AMA) 603
MEDIPHONE Service available (John G. Bellows) 603
Measles high cause of death (Franklin D. Yoder) 604
Announcement from the Rheumatic fever registry (Sophie Levinson)604
Mesenteric embolus (**SURGICAL GRAND ROUNDS**) editor, John Beal 121
Modrijan, Ann A., jt. author, Trends in gonorrhea ecology (Leonida and Dogot) 199
Moran, John F., jt. author, (**EKG OF THE MONTH**) 49, 135, 215, 432, 472, 583
Moss, Bertram B., The future for long term care 577

N

Nemickas, Fimgaudas, jt. author (**EKG OF THE MONTH**) 49, 135, 215, 432, 472, 583
NEW PHARMACEUTICAL SPECIALTIES (Paul DeHean) 59, 102, 234, 420, 510, 000
Nichols, Ronald Lee, (**TRAUMA CENTER**) jt. author, Infections following abdominal trauma 50
Nutritional status, of pre-school children in the United States 1968-70, Aspects of, 156

O

OBITUARIES 64, 160, 254, 436, 532, 608
Officers of county medical societies (**REFERENCE ISSUE**) 327
O'Leary, James A., jt. author, Sarcoma botryoides of the cervix (Lambrecht) 33
Osler-Rendu-Weber Syndrome and Merckel's diverticulum (**SURGICAL GRAND ROUNDS**) editor, John Beal 195
Owen, George M., Aspects of nutritional status of preschool children in the United States 1968-70, 156

P

Peptic ulcer in air traffic controllers, (Richard Grayson) 111
PHARMACEUTICAL SPECIALTIES, NEW 59, 102, 234, 420, 510
Physician placement and student loan fund program (**REFERENCE ISSUE**) 354
Plan for organization of emergency services on Chicago's north side (**TRAUMA CENTER**) (David Forkosh) 209
Policy manual of the ISMS 1972-73 (**REFERENCE ISSUE**) 316
Post ragweed syndrome, (Donald L. Unger) 189
PRACTICE MANAGEMENT
Unemployment compensation and the solo doctor, (Anstett) 62
Understanding Phase II Controls, Part I (Young) 138
Understanding Phase II Controls, Part II (Young) 208
Tax Shelters (Diener) 430
Be your own tax collector (Currie) 508
PRESIDENTS PAGE (Jirka) 8, 96, 171, 276, 452, 554
Program of USDA's food and nutrition service (Hekman) 483
Prolonged pregnancy a problem of declining placental function (Burd & Scommegna) 559
Proposed outline for student notes on hospital charts 533
PULSE OF THE DOCTOR'S WIFE (Mrs. Robert Hartman, editor)
Auxilians attend 69
Illinois Auxiliary attend AMA-WA-AMA Conference 154
Make policy, not coffee (Mrs. Allan (Pam) Taylor) 222
From the president's desk (Mrs. August (Liva) Martinucci) 507, 586

R

Recommendations (ISMS) on smallpox immunization 526
Recurdescence of preventable communicable diseases (Abraham Gelperin) 218
REFERENCE ISSUE 299
Reid, Stephen E., Medical aspects of college football 191
Reiter's syndrome treated with methotrexate (Szanto and Rubenstein) 467
"Right" to medical care (**EDITORIAL**) T. R. Van Dellen 198
Robinson, Sol K., The relationship of degenerative diseases to blood pressure 116
Rubinstein, Herbert, Reiter's syndrome treated with methotrexate 467

S

SAMA-MECO project 490
Sarcoma Botryoides of the cervix, (Lambrecht and O'Leary 33
Scanlon, Patrick, jt. author (**EKG OF THE MONTH**) 49, 135, 215, 432, 472, 583
Schaffner, Robert M., An FDA overview of nutritional guidelines and nutritional labeling 205
Schools without walls, (**EDITORIAL**) T. R. Van Dellen 129
Selected findings of the ten-state nutrition survey (Trowbridge) 473
Sickle cell disease, The value of the screening program on the incidence of (Friedell and Sion) 124
Sion, Albert, jt. author, The value of the screening program on the incidence of sickle cell disease, (Friedell) 124
Smallpox immunization, ISMS Recommendations 526
Smith, Robert E., Industry's response to nutritional challenges 573
Society of critical care medicine, (David Allan) 128
Split real estate concepts (**INVESTMENT CORNER**) (Higgins) 216
Student notes on hospital charts, ISMS proposed outline 533
Support IMPAC 147
SURGICAL GRAND ROUNDS, edited by John M. Beal
- Toxic goiter and pregnancy 37
- Mesenteric embolus 121
- Osler-Rendu-Weber syndrome and Merckel's diverticulum 195
- Operation for lymphedema 494

Szanto, Martin, Reiter's syndrome treated with methotrexate (Rubenstein) 467

T

Talano, James V., jt. author (**EKG OF THE MONTH**) 49, 135, 315, 432, 472, 000
Tavs, L. V., Venereal disease today, part I, 529; part II, 588
Tax Shelters (**PRACTICE MANAGEMENT**) 430
Ten-state nutrition survey, Selected findings, (Trowbridge) 473
Thadepalli, Haragopal, (**TRAUMA CENTER**) jt. author, Infections following abdominal trauma (Nichols and Gorback) 50
The future for long term care, (Bertram B. Moss) 577
(The) **PRESIDENT'S PAGE** (Frank J. Jirka, Jr.) 8, 96, 171, 276, 452, 554
The relationship of degenerative diseases to blood pressure (S. K. Robinson) 116
The value of the screening program on the incidence of sickle cell diseases. (Sion and Friedell) 124
Tobin, John R., jt. author, (**EKG OF THE MONTH**) 49, 135, 215, 432, 472, 583
Too many doctors take the wrong Rx (**INVESTMENT CORNER**) 61
Toxic goiter and pregnancy (**SURGICAL GRAND ROUNDS**) editor, John Beal 37
TRAUMA CENTER
- Infections following abdominal trauma (Nichols, Thadepalli and Gorback) 50
- A new health professional; the trauma coordinator (Mains, Boyd, and Flashner) 158
- A plan for organization of emergency services on Chicago's north side (Forkosh) 209
- A preview: a total emergency medical system for Illinois 486
- The injured posterior urethra (Clark) 599

Trends in gonorrhea ecology, (Leonida, Modrijan and Dogot) 199

U

Underachievement and some associated syndromes (Abrams, Venecko and Abrams) 478
Understanding phase II Controls (Noel Young) (**PRACTICE MANAGEMENT**) Part I, 138; Part II, 208
Unemployment compensation and the solo doctor (**PRACTICE MANAGEMENT**) 62
Unger, Donald L., Post ragweed syndrome 189

V

Van Dellen, T. R., (**EDITORIAL**) 63, 139, 198, 443, 470, VD Treatment 142
Venereal disease today part I, part II (L. V. Tavs) 529, 588
VIEWBOX, Leon Love 43, 130, 204, 418, 522, 582

W

WHAT GOES ON 67, 134, 224, 418, 522, 602
Woman's Auxiliary (**PULSE**) 69, 154, 222, 358, 507, 586

Y

Year-End tax planning (Lloyd A. Byerhof) **Investment Corner**, 580
Young, Noel (**PRACTICE MANAGEMENT**) Understanding phase II controls Part I, 138; Part II, 208

CLASSIFIED ADVERTISING

Positions & Practice Opportunities

PHYSICIAN FOR ACUTE ILLNESS DEPARTMENT and Emergency Room. Become a port of an expanding, dynamic multispecialty clinic in Midwest university community. Excellent salary, benefits. Write or call Medical Director, Carle Clinic, Urbana, Illinois 61801. Phone (217) 337-3239.

UNIVERSITY HEALTH SERVICE POSITIONS OPEN: General Practitioner, Pediatrician, or Internist, full-time, for Medical Clinic. General Practitioner, full-time or Gynecologist for office gynecology and family planning services. (Gynecologist may elect to practice part-time in Chicago or Rockford.) Psychiatrist, full-time, for patient therapy and to head Mental Health Unit. Modern facility, good fringe benefits. Illinois license required; salary per qualifications. L. W. Akers, M.D., Director, UHS, Northern Illinois University, DeKolb, Illinois 60115.

IMMEDIATE OPENING for OB-GYN, Internal Medicine, and Orthopedic specialties to establish successful practice with 14-man multi-specialty group. Excellent group benefits; pension plan; modern clinic facilities; progressive community with excellent educational system including two colleges; city population 35,000; good recreational facilities; each specialty must be board eligible or certified; young man with military obligation completed. Contact: Business Manager, The Manitowoc Clinic, 601 Reed Avenue, Manitowac, Wisconsin 54220.

WANTED: OB-GYN, SURGEON and INTERNIST for nine man group. Thirty miles southwest af Chicago, excellent hospital, housing and schools. $30,000 guarantee first year. Write to Box Number 782, c/o Illinois Medical Journal, 360 N. Michigan Ave., Chicaga, Illinois 60601.

IMMEDIATE OPENING: INTERNIST ar **GENERAL PRACTITIONER** to join six man multi-specialty group in northeastern Wiscansin. Excellent professional opportunity to practice in a friendly community, only two actively practiticing physicians (General Practitioners) in the community outside of our Clinic. Salary commensurate with training and experience first year and then full partnership. Ideal, safe small city living for the family on scenic Lake Michigan with excellent fishing, boating and hunting. All this and still only 1½ hours drive to Milwaukee or 45 minutes to Green Bay or lovely Door County. For complete details contact Robert E. Myers M D Garfield at 23rd Two Rivers, Wisconsin 54241.

GENERAL PRACTITIONER—Excellent location in the Lost Pines of Texas area, growing community of 3,500 along the beautiful Colorado River. Has an exrellent oooortunity for a good family General Practitianer. Excellent small Hospital (25 beds) and Nursing Home (65 beds) complex, guaranteed salary if desired, clinic, ancillary services and other fringe benefits will make this difficult to turn dawn if interested in working in a progressive rural community only 40 miles from a metropolitan area. Smithville Hospital Authority; Irvin Row, Administratar, Box 89, Smithville, Texas 78957. Phone: AC 512-237-2441.

OPENING FOR PHYSICIAN (GENERAL MEDICINE OR INTERNIST) on Medical Service, 184-Bed GM&S VA HOSPITAL well equipped and staffed including consultants. Affiliation with SIU School of Medicine. Beginning salary depending on qualifications. Excellent vacation, insurance and retirement benefits. No maximum age. Excellent area recreational facilities and cultural activities at nearby Southern Illinois University. Equal Opportunity Employer. Inquire: Director, Veterans Administration Hospital, Marion, Illinois 62959. Call (618) 993-2151.

PATHOLOGIST WANTED: Board eligible, Illinois licensed for vocation coverage. $600 per week. Contact James Gross, M.D., pathologist. St. Mary's Hospital, Streator, Illinois 61364. Phone: (815) 673-2311 Ext. 219.

PART-TIME LOCUM in Beautiful Suburban Clinic. Hours arranged to suit. General and E.R. Practice. Liberal Hourly Salary. Write: G. A. Caress, 2320 W. High Street, Blue Island, Illinois 60406, or Call (312) 388-5500.

GENERAL PRACTITIONERS WANTED—Are you bored and want a challenge? Do you want to practice where they don't ask about your diplomo, or your specialty? Are you genuinely interested in people and their problems, rather than diseases and cases? If so, come on down to Fairfield and get your feet wet! Write or phone collect: Jerry Vaughan, Box H, Fairfield, Illinois 62837. Telephone (618) 842-2167.

PSYCHIATRIC STAFF—Requirements of three year residency training to Boord Certified. $26,000 to $36,000 depending upon qualifications. Dramaticolly beautiful, leisurely paced cultural, summer-winter vacationland. Superb sailing, skiing, fishing. Resident theater. Near Interlochen National Music Camp. College. J.C.A.H. approved 1,400 bed psychiatric hospital. Three yeor psychiotric residency program. Excellent fringe benefits. Contact Philip B. Smith, M.D., Room 321, Traverse City State Hospital, Traverse City, Michigan 49684. An equal oportunity employer.

WANTED . . . PHYSICIAN to practice in new clinic. Ideal location in county seat of Marquette County. Progressive community in resort and recreation area. Excellent place to live. Contact: Mayor Ken Bentley, Montello, Wisconsin. Telephone: 297-2474.

GENERALIST WANTED: For full-time student health position. 40 hour week, no call, excellent environment. Salary negotiable, fringe benefits including 30 days vacation and retirement plan. Illinois License. Write or call: Margaret M. Torrey, M.D., Illinois State University, Normal, Illinois 61761. Ph. (309) 438-8655.

HOUSE PHYSICIAN: Northwestern Illinois 72-Bed General Hospital with chest unit. 40 hours a week, salary—$30,000 up according to experience. Excellent fringe benefits. Write to Box Number 810, c/o Illinois Medical Journal, 360 N. Michigan Ave., Chicago, Illinois, 60601.

RESIDENCY IN RADIATION THERAPY—Major radiation therapy center affiliated with four universities, with modern newly equipped facilities and active clinical teaching program available January 1 and July 1, 1973. Stipend commensurate with previous experience. Apply Dr. S. Stefani, Chief Therapeutic Radiology Service, V.A. Hospital, Hines, Illinois 60141. An Equal Opportunity Employer.

FOR SALE, LEASE OR RENT

MEDICAL BUILDING, MOLINE, ILLINOIS—Outstanding opportunity for professional man starting his practice or planning relocation of his practice. Beautiful modern office with all modern facilities only half mile from modern hospitals area Trauma Center in Illinois. Call (309) 762-3397. Moline, Illinais.

OFFICE SPACE in excellent location available for General Practitianer or Specialist. Call (312) 746-2046—Zion, Illinois.

FOR RENT AND SALE: Office Space, ideal location, west suburban Bellwood; furniture and medical equipment for sale due to death of physician. Certain items such as spectrophotometer (new), EKG, laboratory items, Coleman diathermy, new electronic stethoscope for sale, separately if desired. Practice also may be assumed through orrangements with Executor. Write Box Number 806, c/o Illinois Medical Journal, 360 North Michigan Ave., Chicago, Illinois 60601.

PRACTICE FOR SALE—Estate Sale, Marshall Erdmann Medical Building, 1500 sq feet, 9 rooms, 3 examining rooms, Central air conditioning and heating, modern facilities and equipment including X-ray. Situoted in quiet, scenic Southern Illinois—mild climate. (2) hospitals within 5 mile radius, on major transcontinental travel routes; Major University with Law and Medicol School 20 miles oway. Fantastic recreational possibilities nearby; 230,000 acres Shawnee Notional Forest—superb hunting and fishing in 20 minutes drive; 9 major lakes and 2 major rivers. Foreign born medical graduate grossed far into six figures here. Ideol for one or two doctors. Please call collect (618) 983-7301 or send inquiries to Mrs. Rotroud Rupprecht, 802 Washington, Johnston City, Illinois 62951.

FOR SALE: Lucrative 25 year old generol practice one hour drive from Downtown Chicago. Will introduce. Unlimited opportunity for male and female medical doctors. Write to Box Number 807, c/o Illinois Medical Journal, 360 No. Michigan Ave., Chicago, Illinois 60601.

OFFICE PRACTICE in **CHICAGO** for sale. Retiring. Lucrative Bariotric Proctice (WEIGHT CONTROL). Write to Box Number 809, c/o Illinois Medical Journal, 360 N. Michigan Ave., Chicago, Illinois 60601.

FAR WESTERN CHICAGO SUBURB. Over 3,000 records in files. Grossing $9,000 to $12,000 per month. Option to buy practice for $3,000 or rent space in this going clinic with option to join group.

CHICAGO. Doctor moving for health reasons must sacrifice practice located in prime medical building. Grossing $85,000. Total purchase price $5,000. Buyer also has opportunity to purchase 25 percent interest in medical building.

OTHER EXCELLENT PRACTICES AVAILABLE through Illinois, Wisconsin and Indiana. No fee to buyers. Financing ovoilable. Strictly confidentiol.

PROFESSIONAL PRACTICE SALES, 540 Frontoge Road, Northfield, Illinois 60093; 312/441-6111.

FOR SALE: Attractive Colonial Medical Building (located 25 miles West of downtown Chicago in suburbon La Grange) has one suite, 7 rooms plus receotion and private parking area. Immediately availoble for leose. Call Jock Roodhouse 354-9250. Rich Port, Realtor, 547 S. La Grange Rood, La Grange, Illinois.

EKG of the month

(Continued from page 583)

Answers:

1E; 2A and B. A QRS conduction delay is present because the QRS duration is 0.12 seconds. The initial portion of the QRS is abnormal showing an absence of Q waves in leads I, avL, V_5 and V_6. These findings added to the notched QRS in leads V_5 and V_6 make a diagnosis of left

Bundle branch block because the T waves are upright in leads I and V_6 whereas typically they are inverted. When these T waves in leads I and V_6 are inverted, they are called secondary T waves changes, i.e., they are the result of changes in the QRS of left bundle branch block. But when these T waves are upright in I and V_6, as they are here, they are called primary T wave changes because they are thought to be a result of some change in the rate of recovery or duration of the excited state in portions of the ventricular muscle. These changes are more than those of typical left bundle branch block. These primary T wave changes could be the result of myocardial ischemia, electrolyte imbalance, digitalis or quinidine effects, thyroid disease, or even beriberi. The important point is they are a clue that something else is occurring in addition to the left bundle branch block. This patient had angina pectoris and responded to treatment with nitroglycerin both therapeutically and prophylactically. Her ECG of left bundle branch block with primary T wave changes is compatible with her clinical diagnosis. For an example of typical left bundle branch block please refer to the December 1971, *IMJ* EKG of the Month. ◄

APPROVED AVAILABLE NOW!
ISMS
MALPRACTICE INSURANCE

Professional Liability Insurance Program
Approved for Members
REGARDLESS of AGE or SPECIALTY

Protect Doctor's Integrity
Company will settle no claims without insured member's approval. Nuisance claims *will* be fought.

Improve Legal Climate
Company will retain outstanding defense counsels who are experts in professional-liability cases.

Provide Market Stability
Company will maintain an available market. Participation by the members is needed to assure this market.

Keep Members Informed
Company will tell members how to prevent claims . . . keep them aware of latest legal developments in malpractice field.

ISMS Supervision And Control
Premiums to reflect only the loss experience of ISMS. All questionable underwriting cases to be reviewed by ISMS. A UNIQUE FEATURE

FOR INFORMATION, ASSISTANCE & DETAILS CONTACT ADMINISTRATORS:

PARKER, ALESHIRE & COMPANY
ESTABLISHED 1901
Insurance

9933 N. Lawler Avenue
Skokie, Illinois 60076
Phone: 312-679-1000

IMJ Illinois Medical Journal

your advertisers

Our Advertisers serve the Medical Profession and support your Journal. All advertisers are approved by your Journal Committee. It will help you and your society to mention your Journal when writing them.

Space Representatives:
United Media Associates, Inc.
16 Bruce Park Avenue
Greenwich, Conn. 06830

CLASSIFIED ADVERTISING 616

INSURANCE

Medical Protective 590

Parker, Aleshire, & Co. 610, 617

PHARMACEUTICALS

Beecham-Massengill Div., Beecham, Inc.
Ampicillin 607
Carbenicillin 609
Oxacillin 611

Burroughs Wellcome & Company
Neosporin Ointment 2nd Cover

Endo Laboratories, Inc.
Percodan 552-553

Eli Lilly and Company
Ilosone Liquid 250 558
Trinsicon 591-592

Loma Linda Foods
Medical Products Division
Soyalac 549

Wm. Poythress Co., Inc.
Uro-Phosphate 540

Roche Laboratories
Librium 550-551
Valium Back Cover

Stuart Pharmaceutical Div., Division of I.C.I. America Inc.
Kinesed 542-543

The Upjohn Company
Orinase 539

SERVICES & CONTINUING EDUCATION

American National Bank 547
Blue Cross/Blue Shield 535-537
Cook County Graduate School of Medicine 611
E & M Medical Laboratories, Inc. 611
INTRAV/*Scandinavian Adventure* 546
Mail Order Mart/*Typewriter Ribbon* 608
Modern Medicine Publications/*Med. Tours* 552
Pharmaceutical Manufacturers Association 555-557

X74-3918

Illinois medical journal.
v.142, 1972.

DATE | ISSUED TO

NOV
J

X74-3918

Illinois medical journal.
v.142, 1972.

RETURN THIS BOOK ON OR BEFORE LAST DATE STAMPED

NOV 6 '75
NOV 6 1975
MAY 3 '76
RET'D. APR 27 1976
JUL 29 '76
RET'D. JUL 28 1976
DEC 23 1976
DEC 6 '77